



**HAI H. NGUYEN, DDS, MS, PA**  
**PERIODONTAL IMPLANTS**

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***Referral Form***

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like us to establish contact with Patient? \_\_\_\_\_

***Patient is Being Referred for:***

*Please check all that apply*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Generalized Periodontitis | <input type="checkbox"/> Osseous Surgery    | <input type="checkbox"/> Root Tip        |
| <input type="checkbox"/> Localized Periodontitis   | <input type="checkbox"/> Bone Regeneration  | <input type="checkbox"/> Extractions     |
| <input type="checkbox"/> Tissue Grafting           | <input type="checkbox"/> Sinus Lift         | <input type="checkbox"/> 3rd Molars Ext. |
| <input type="checkbox"/> Crown Lengthening         | <input type="checkbox"/> Ridge Augmentation | <input type="checkbox"/> Stomatology     |
| <input type="checkbox"/> Distal Wedge              | <input type="checkbox"/> Site Preservation  | <input type="checkbox"/> Kodak 3D CT     |
| <input type="checkbox"/> Biopsy Services           | <input type="checkbox"/> Abscess            |  |
| <input type="checkbox"/> Frenectomy                | <input type="checkbox"/> Bone Grafting      |  |

**Implant Placement**

**Sedation**

- Nobel  
 Thommen  
 Bio Horizons  
 Other \_\_\_\_\_

- IV Conscious Sedation  
 Oral Conscious Sedation  
 Nitrous Oxide

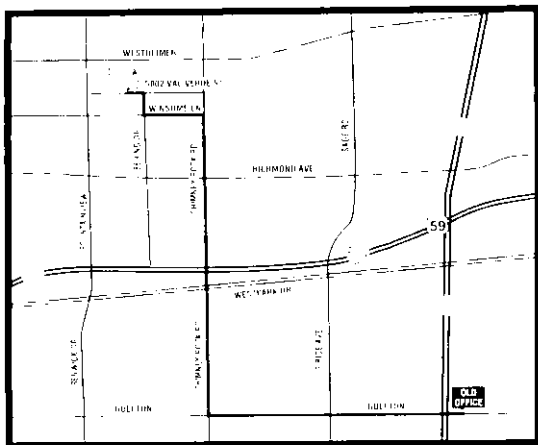
Provider Name: \_\_\_\_\_

Email: \_\_\_\_\_

Comments: \_\_\_\_\_

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***Thank you for your referral!***  
***We appreciate your confidence in our office!***



*Open:*  
**Monday - Thursday**  
**8:00 AM - 4:00 PM**