Referral Form

Patient Name ______________________________ Phone ______________E-mail ______________________
Address ____
Appointment: Day ___________________ Date ______________________ Time ______________________

Reason for referral

☐ Occlusal Equilibration ☐ TMJ Treatment ☐ Periodontal Therapy ☐ Sleep-disordered Breathing

☐ Prosthodontics ☐ Implant Surgery ☐ 3-D Imaging ☐ Lifestyle Medicine

Patient Details

S (Hx) ____
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O (Ex) ____
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A (Dx) ____
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P (TxP) ____
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Dr. _________________________________Date _______________________ Phone ______________________
Signature

Dr. Lon Peckham

C/O The Smile Miracles Project

50 Main St. Ste. 201, Priest River, Idaho

1280 Polston Ave. Post Falls, Idaho

855-55DRLON (855-553-7566)