Dental Laser Center of Chicago
A.R. "Eddie" D.D.S. PC
Board Certified Periodontist
Northwestern University Graduate, 1999

Tel (773) 622-3454
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PPO/HMO/FEE FOR SERVICE

Financing Available

Patient Referral

Patient Name: _____DOB_____ Date: _____

Phone Number:_____

Reason for Referral

- ☐ Comprehensive Periodontal Evaluation
- ☐ Gingivectomy
- ☐ Recession
- ☐ Depigmentation: Gum bleaching
- ☐ Extraction: Tooth removal #_____
- ☐ Tori Removal
- ☐ Crown lengthening
- ☐ Peri-Implantitis #_____
- ☐ Implant: #_____
- ☐ Other:_____

History of SRP: ☐ Yes or ☐ No
If yes, date completed_____

Emergency WALK-IN's, please call us immediately.

WALK-IN HOURS (Must call first) Monday-Thursday 7am-1pm

☐ UR ☐ UL
☐ LR ☐ LL

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R																L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Referred by: _____ Tel: _____

Please send referral and x-rays to dentallaserchicago@yahoo.com