ASHEVILLE PERIODONTICS

Dr. Susanna M. Goggin, D.M.D. P. A.
602 Alliance Court
Asheville, NC 28806

Referral Form

Date: _____

Referring Practice: _____

Patient Name: _____

Patient Phone Number: _____

Patient Details:

_____

_____

_____

_____

_____

_____

If possible, please appoint the patient for a consultation with our office while they are still at your office. When the patient leaves your office, please email the referral information to our office at info@ashevilleperiodontics.com

When emailing the referral slip, please include all radiographs and dental benefit information for the patient being referred. We prefer to have a full mouth series, including vertical bitewings, so we can accurately diagnose, even if you are sending the patient over for a specific issue.

If you do not have digital radiographs capabilities, please mail us a copy of the radiographs to:

Dr. Susanna Goggin

602 Alliance Court

Asheville, North Carolina, 28806

Please let us know if you have any appointment-back preferences. We want to make sure we facilitate the patient going back to your office in a smooth and efficient manner.