ADA American Dental Association

Advanced Prosthodontics & IMPLANT ESTHETICS

ACP American College of Prosthodontists | Your smile ty: Our special

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PATIENT REFERRAL

Introducing: _____

Home#: _____ Work #: _____

Chief Concern: _____

Patient is being referred for evaluation of the following:

- ❑ Comprehensive care including future re-care visits.
- ❑ Comprehensive care excluding future re-care visits.
- ❑ Maxillofacial prosthetic evaluation.
- ❑ Oral evaluation before cancer tx.
- ❑ Limited Exam Tooth #'s _____

Is the patient in need of emergency treatment? ❑Yes ❑No

RESTORATIVE & IMPLANTS

- ❑ Complex Maxillofacial Prosthodontic Case
- ❑ Management of tooth wear
- ❑ Implant Overdenture
- ❑ Hybrid Denture
- ❑ Single Implant Restoration
- ❑ TMD / Pain
- ❑ Smile Makeover

Teeth involved #_____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Remarks or special instructions including alternative tx discussed:

_____

_____

_____

Referring Dr. _____ Date: _____

Referring Dr. Phone#_____

Appointment Date & Time _____

Thank you for your kind referral!