DENTAL SPECIALTIES Northwest

World Class Providers | Integrated Care | Exceptional Comfort

ESTHETICS/PROSTHODONTICS

Introducing: ______________________________________

Home Phone: __________________ Work Phone: __________________

Referring Doctor: ____________________

Referring Doctor's Phone: __________________ **Today's Date:** _____________

Appointment: (please check correct box)

Patient has appointment. **Date:** _____________ **Time:** _______

☐ Patient will call for appointment.

☐ Please call patient for appointment.

Reasons for referral: (please check all, that apply)

☐ CT Scan (specify area) ________________________

☐ Cosmetic Dentistry (bleaching, bonding, porcelain veneers or inlays)

☐ Fixed Prosthodontics (crowns or bridges)

☐ Removable Prosthodontics (dentures or partials)

☐ Implant Dentistry: (specify area) ________________________

Radiographs and records: (please check all that apply)

☐ Radiographs will be forwarded. Note type and date:

☐ Radiographs not available. Advise patient that radiograph may be necessary.

☐ Other records will be fowarded. List: ________________________________

Comments / Medical Alerts / Patient Concerns:

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