smile by design DENTAL GROUP

PATIENT REFERRAL

www.ImplantDentistIrvine.com
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INTRODUCING: _____

APPOINTMENT DATE & TIME: _____

Please call 949.786.2820 to schedule your patient's appointment.

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

DATE:_____ REFERRING DR. _____ PHONE:_____

This patient is being referred for evaluation of the following:

RESTORATIVE / OPERATIVE CARE

- ☐ Broken Post Tooth #___
- ☐ Esthetic Emergency - same day or next morning Tooth #___
- ☐ Extractions and Partial or Full Denture Fabrication Tooth #___
- ☐ Fractured Fixed Partial Denture (Bridge) Tooth#__
- ☐ Match Single Central or Other Anterior Tooth#__
- ☐ Tooth Wear with Broken Restoration(s) Tooth#__
- ☐ Other (specify): _____

Complex Prosthodontic Care:

REMOVABLE PROSTHODONTICS

- ☐ Complete Denture *(circle one: Upper / Lower / Both)*
- ☐ Immediate / Interim Denture *(circle one: Upper / Lower / Both)*
- ☐ Partial Denture *(circle one: Upper / Lower / Both)*
- ☐ Other (specify): _____

IMPLANT PROSTHODONTICS

- ☐ Single tooth implant
- ☐ Multiple teeth implants
- ☐ Implant supported dentures

RECONSTRUCTION

- ☐ Full mouth reconstruction who lost total function
- ☐ Other (specify): _____

- ☐ TMJ

Comments: _____

☐ **Please call me before proceeding with treatment.** ☐ **I have sent radiographs for your evaluation.**

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