

Prescription for Dental Implants

Patient: _____

Referred to: _____ Date of appointment ____/____/____

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Remove portion above line and give to patient - transmit portion below line to Dr. Schnitman

Prescription for Dental Implants

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH: ____/____/____

ADDRESS: _____
street city state zip

TELEPHONE: _ (____) _____ (____) _____
home work

Proposed Treatment

1) COMPLETE MAXILLA ___ Fixed porcelain ___ Fixed profile prosthesis ___ Removable overdenture ___ To be discussed		2) COMPLETE MANDIBLE ___ Fixed porcelain ___ Fixed profile prosthesis ___ Fixed hybrid ___ Removable overdenture ___ To be discussed	
3) ___ PARTIAL FIXED	4) ___ SINGLE TOOTH	5) OTHER _____	
<u>Edentulous Regions</u> 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 right _____ left 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17			
Comments particular to this patient: _____ _____			

REFERRING DENTIST INFORMATION

NAME _____

TELEPHONE: _ (____) _____ Fax _ (____) _____

___ Please see my patient for consultation. ___ I desire to be present at surgery.

___ I desire the assistance of Dr. Schnitman with this patient.

___ Other _____

Signature of referring dentist _____