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IMPLANT PATIENT REFERRAL FORM

Please provide us with as much information as possible about this patient. The more we know about the patient and your restorative plans, the better prepared we are to meet this patient's needs.

PATIENT NAME: _____

REFERRED BY: _____

X-RAYS SENT: ____ PA ____ PAN ____ CT PLEASE TAKE NEW X-RAYS: _____

EXTRACTIONS REQUIRED: ____ YES ____ NO IF "YES", TOOTH # _____

PATIENT NEEDS APPLIANCE: ____ YES ____ NO IF "YES", THE APPLIANCE WILL BE
DELIVERED TO THE SURGICAL OFFICE BY _____

IMPLANTS: PRELIMINARY TREATMENT PLAN / RECOMMENDATIONS

MAXILLA _____

MANDIBLE _____

PATIENT INFORMATION:

MEDICAL HISTORY: ____ NOTHING SIGNIFICANT/ UNUSUAL ____ COMPLICATED

Please feel free to share any additional information you think we should know about this patient (e.g. specific patient concerns) before the consultation.

FEES:

PATIENT HAS AN ESTIMATE OF THE RESTORATIVE COSTS: ____ YES ____ NO

PATIENT HAS BEEN GIVEN RANGE / ESTIMATE OF SURGICAL COST: ____ YES ____ NO