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Referral Form

Patient Name: **Last** _____ **First** _____ **Date** _____

Patient Contact: **Email** _____ **Home** _____ **Cell** _____

Referring Doctor: _____ **Email** _____

☐ Consultation for Implant – #'s _____

- ☐ Full-Arch Fixed Restorative Case (All-on-Four) ☐ Maxilla ☐ Mandible
- ☐ Immediate placement after extraction if possible

Implant System Preference:
- ☐ No Preference
- ☐ Nobel Biocare
- ☐ Astra Tech
- ☐ Other: _____

Surgical guide:
- ☐ Surgeon to fabricate
- ☐ Restorative will provide
- ☐ CT guided surgery
- ☐ Diagnostic wax-up provided

☐ Extraction of Teeth _____ ☐ with immediate bone grafting if needed

☐ Bone Grafting of _____

☐ Third Molar Removal _____

☐ Exposure of teeth _____ ☐ Attach bracket and chain ☐ Exposure only

☐ Biopsy _____

☐ Infection _____

☐ Apical Salvage Surgery _____

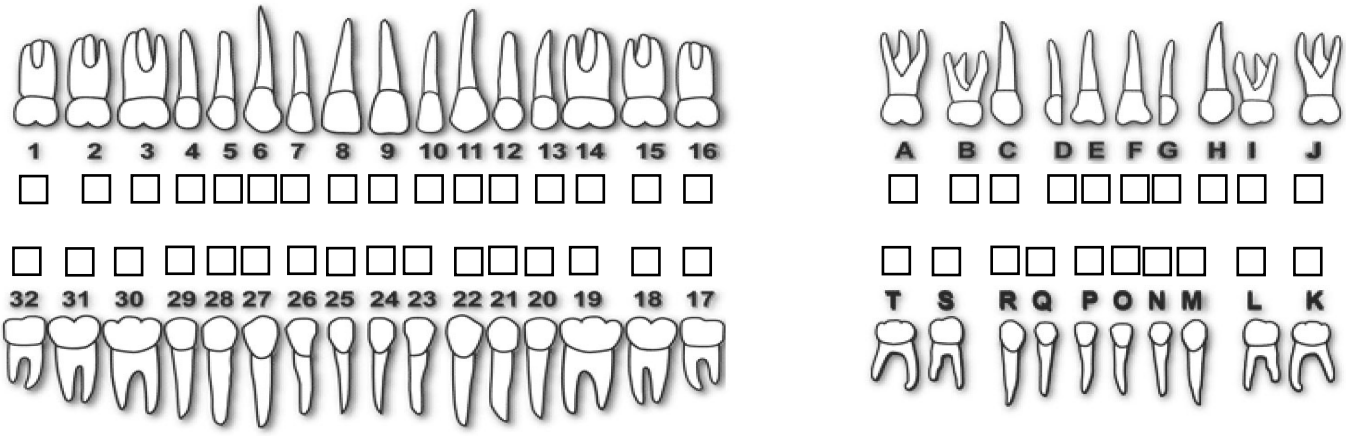
☐ Pre-prosthetic Surgery _____

☐ Frenectomy _____

☐ TMJ Evaluation and Treatment

☐ Orthognathic Evaluation

Extraction of teeth (Mark with 'X")



Please verify teeth for extraction – #'s _____

Images (x-rays): ☐ Will be emailed ☐ Please take ☐ Will be mailed ☐ Given to patient

Comments:

_____
Signature