

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 _____

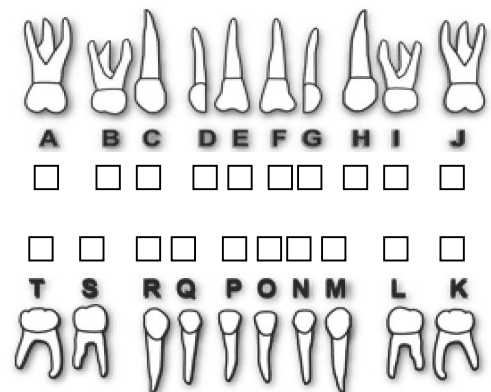
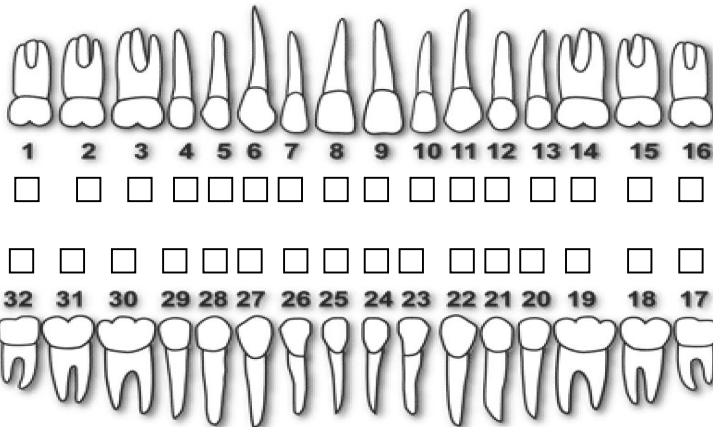
Pre-prosthetic Surgery _____

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