

REFERRAL FOR TREATMENT

Patients Name: _____

Telephone: _____ Date Of Referral: _____

Referring Doctor & Phone: _____

Please check all that apply:

- Please call Patient
- Patient will call you
- X-ray imaging is sent by (circle one): Courier / E-mail / With the patient
- Dental insurance information is enclosed

TREATMENT requested:

18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38
55 54 53 52 51	61 62 63 64 65
85 84 83 82 81	71 72 73 74 75

- Extractions
- Bone Grafting / Socket grafting / Ridge preservation
- Sinus Lift (Crestal / Lateral)
- Implant Surgery (Delayed or Immediate)
- Implant Provisionalization (Temporary)
- Final Prosthetic Restoration (Implant Crown)
- Full Arch Rehabilitation (Locator Overdenture, All-on-X)
- Connective Tissue/ Free Gingival Grafting
- Cone Beam CT Scan (10x10 FOV)

Additional Comments: _____

