

PATIENT REFERRAL FORM



ADSG
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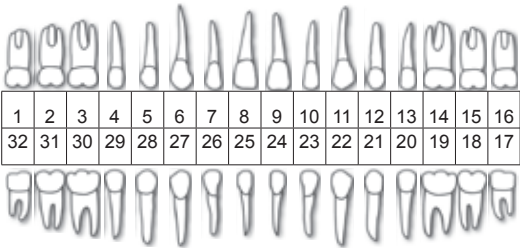
PATIENT: _____ DATE: _____

REFERRING DOCTOR: _____

PHONE NUMBER: _____

EXODONTIA EVALUATION

Exodontia (Please Indicate Teeth Below)



Special Instructions: _____

IMPLANT EVALUATION

Location: Tooth #(s) _____

If Exodontia - Please check:

- Fixed Removable (Locator)
- All-On-4 Treatment Concept
- Implant Crown and Bridge

Retention of Prosthesis: Cement Retained
 Screw Retained

Provisionalization: Removable Fixed None

Bone Grafting: Socket Restoration/Maintenance
 Ridge Augmentation
 Sinus Augmentation

SIGNED: _____ DATE: _____