

Seattle
SPECIALTY DENTISTRY

PROSTHODONTICS

Recognized leaders in cosmetic, restorative and implant dentistry

Introducing: _____

Home Phone: _____ Work Phone: _____

Referring Doctor: _____

Referring Doctor's Phone: _____ Today's Date: _____

Appointment: (please check correct box)

- Patient has appointment. Date: _____ Time: _____
- Patient will call for appointment.
- Please call patient for appointment.

Reasons for referral: (please check all that apply)

- CT Scan (specify area) _____
- Cosmetic Dentistry (bleaching, bonding, porcelain veneers or inlays)
- Fixed Prosthodontics (crowns or bridges)
- Removable Prosthodontics (dentures or partials)
- Implant Dentistry: (specify area) _____

Radiographs and records: (please check all that apply)

- Radiographs will be forwarded. Note type and date: _____
- Radiographs not available. Please advise patient that radiograph may be necessary.
- Other records will be forwarded. List: _____

Comments / Medical Alerts / Patient Concerns _____
