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Prosthodontics, Implant and Esthetic Dentistry
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Referring Doctor: _____, Date: _____-_____-_____

Introducing:
_____

Home Phone # _____-_____- _____ , Office # _____-_____-_____

Please evaluate for the following treatment:

€ **Fixed** € **Removable** € **Implant**

€ **Full Mouth Reconstruction** € **Esthetic Dentistry**

X-ray and Photos: € **Sent by mail** € **Sent with patient**

€ **To be taken** € **Send by E-mail**

Appointment Status: € **Urgent** € **Call to discuss**

Areas of Concern

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

€ **Evaluation only** € **Evaluate and Treat**

€ **Phone Conference** € **Written Report**

€ **Refer patient back for treatment**

Remarks and Recommendations:
_____

_____
Please fax to 408.252.4347 or e-mail to chustaff@gmail.com.
Thank you