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Referral Request

Date_____

Introducing: _____

Evaluation/ Treat:

- ❑ Comprehensive Exam
- ❑ Extraction
- ❑ Traditional Implants
- ❑ Mini Dental Implants
- ❑ Implant Site Development
- ❑ Socket Preservation Graft
- ❑ Bone Grafting
- ❑ Pain management
- ❑ Veneers
- ❑ Crowns
- ❑ Minor Tooth Movement
- ❑ Cavities/Restorations
- ❑ Post and Core Build-up
- ❑ Root Canal Therapy (anteriors or bicuspids)
- ❑ Laser Frenectomy
- ❑ Cone Beam (CT)
  - ❑ TMJ (R/L)
  - ❑ Sinus (R/L)
  - ❑ UR/LR/UL/LL
- ❑ Panorex
- ❑ FMX
- ❑ Other _____

Tooth No.(s) / Area Below

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

a	b	c	d	e	f	g	h	i	j
t	s	r	q	p	o	n	m	l	k

- ❑ X-Rays Digitally Fowarded
- ❑ X-Rays Given to Patient
- ❑ X-Rays Mailed
- ❑ Please Take X- Rays

Special Instructions or Comments:

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Please call me: ❑ prior to ❑ after seeing patient

Referring Doctor Signature: _____