Advanced Dental Implant Solutions

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Referral Form

PATIENT INFORMATION

Patient Name ________________________________ Phone___________ DOB ____________

Referring Doctor ____________________________ Doctor's Phone_____________________

Today's Date_______________

Treatment Request

Implant Prosthodontics

Full arch implant bridge (A04) _____ Implant bridge_____ Implant crown_______

Immediate loading _______ Implant overdenture _______

Fixed Pros

Full arch/single ______ Loss of DVO_______ Partial Bridge______

Smile Analysis and Treatment______

Removable Pros

Complete Dentures___________ Partial Dentures___________ Obturators___________

Maxillofacial Prosthodontics__________

Comprehensive Prosthodontic Evaluation_______ **Limited Prosthodontic Evaluation**______

Temporomandibular Disorder _______

Radiographs/ Photos: Mailed_______ Given to Patient_______ None_______

Other: ____

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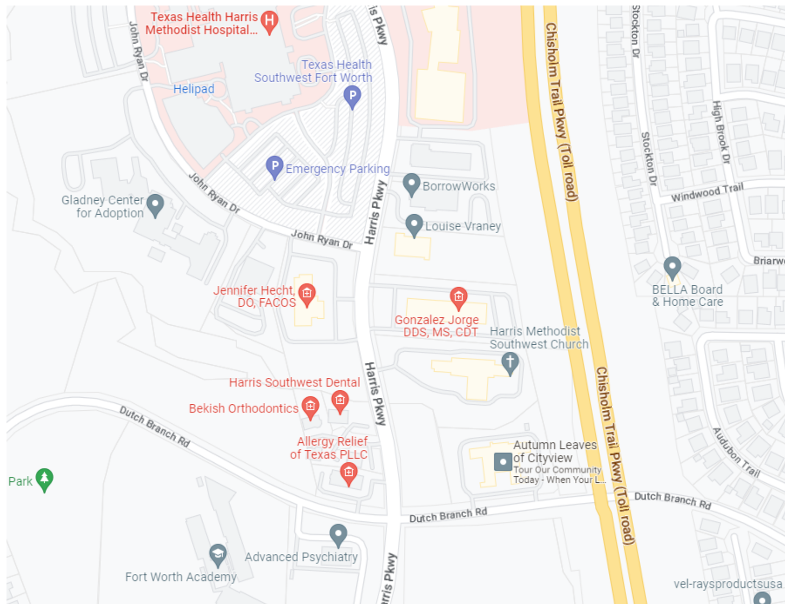
PLEASE REMEMBER THE FOLLOWING FOR YOUR EVALUATION

- Usually your first visit is a consultation visit only
- Bring with you x-rays, dental records and study models if available or have your doctor mail them to us to **drgonzalez@advanceddentalimplantsolutions.com**
- This time has been reserved exclusively for you, please call 817-882-8282 at least 48 hours in advance if you are unable to keep this appointment

Thank you for choosing Advanced Dental Implant Solutions !



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