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- IMPLANTS
- COSMETIC
- RECONSTRUCTIVE DENTISTRY
- PROSTHODONTICS

Patient Name: _____ **Phone Number:** _____

Please evaluate this patient for the following prosthodontic treatment(s):

_____ Complete and/or Partial Dentures _____ Implant restoration
_____ Full Mouth Rehabilitation _____ Localized treatment of _____

Clinical Information:

Recent Treatment:

Radiographs:

_____ Will be sent to you _____ Accompany the patient _____ Please take new radiographs

Surgical Treatment:

_____ Pending
_____ Implant Surgery Scheduled Date: _____
_____ Implant Surgery Completed Date: _____

Implants Placed:

Tooth Number(s): _____

Type: _____

Size: _____

Prognosis:

☐ Dr. Rimes, please call referring doctor before patient is seen.

☐ Dr. Moleta, please call referring doctor before patient is seen.

Please fax this form to 281.313.1575 and give form to patient

Referred By: _____ Phone: _____