APEX Prosthodontics
crafting confident smiles

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Patient: _____
Phone #: _____
Email: _____

Referring Doctor: _____
Office phone: _____
Office email: _____
Date: _____

Appointment:
- ☐ Please call patient
- ☐ Patient will call

Type of Referral:
- ☐ Limited treatment
- ☐ Comprehensive care

Prosthodontic Treatment Needs:
- ☐ Comprehensive treatment
- ☐ Dental Implants
- ☐ Fixed Prosthetics
- ☐ Removable Prosthetics
- ☐ Esthetics / Cosmetic Dentistry
- ☐ Occlusion
- ☐ Other

Remarks:

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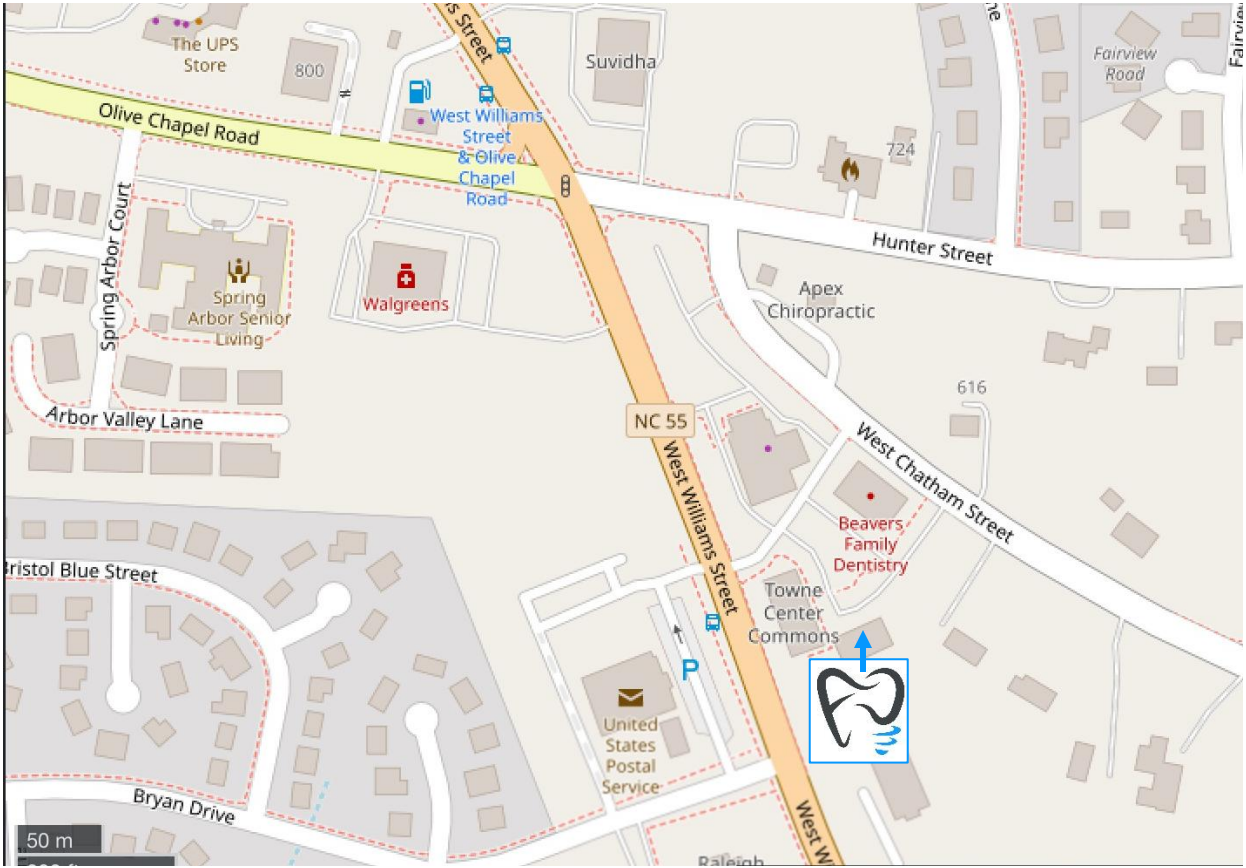
Enclosed or emailed: X-rays _____ Chart Notes: _____ Photos : _____
Please take updated radiographs: _____

If the referral is implant-related, please include any available implant information

Google Maps

Apple Maps



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