APEX Prosthodontics
crafting confident smiles

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1440 Chapel Ridge Rd
Suite #200
Apex, NC 27502

Patient: _____
Patient Phone: _____
Email: _____

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

Appointment Scheduling:

☐ Please call patient
☐ Patient will contact your office

Type of Referral:

☐ Limited treatment
☐ Comprehensive care

Prosthodontic Treatment Needs:

☐ Comprehensive treatment
☐ Dental Implants
☐ Fixed Prosthetics
☐ Removable Prosthetics
☐ Esthetics / Cosmetic Dentistry
☐ Occlusion
☐ Sleep appliance
☐ Other

Remarks:

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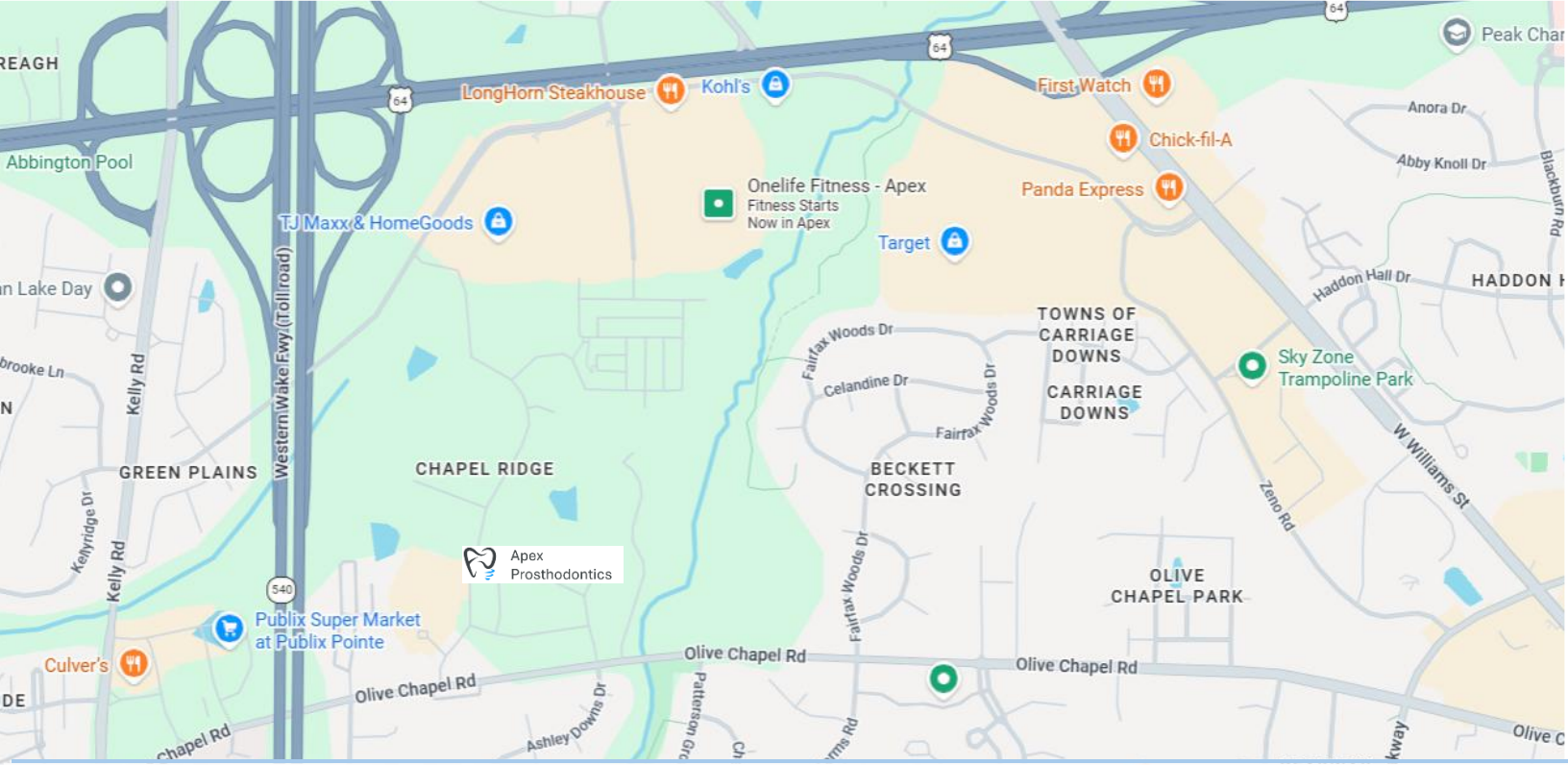
For implant referrals, please include any available implant information (manufacturer, diameter, length, restorative components, or surgical records if available).

Records include: X-rays _____ Chart Notes: _____ Photos : _____
Please take updated radiographs: _____

Thank you for your referral and the confidence you place in our practice. We are committed to providing exceptional specialty care and returning your patient to your practice for continuing dental care.



GOOGLE MAPS

APPLE MAPS

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