Implant
Cosmetic and
Reconstructive Dentistry

I have referred my patient for prosthodontic treatment.

Last Name ________________________ First Name ___________________ DOB ___________________

Telephone (Home) _________________________________ (Cell) _______________________________

Please mark as needed:

- ☐ Comprehensive Evaluation and Treatment
- ☐ Dental Implants
  - ☐ Restored by Georgia Prosthodontics
  - ☐ Restored by Referring Doctor
- ☐ TMJ Evaluation

Any attempts to treat your patient's problem in the past? _________________________________

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Goal of treatment ____

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The following aids are available from my office:

- ☐ Full Mouth Series
- ☐ Panoramic
- ☐ Diagnostic Casts
- ☐ CT Scan

Comments ____

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Referred by ____ Office Phone __________________

Date __________________________

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Buckhead: 3379 Peachtree Rd NE. Suite 830 - Atlanta GA 30326
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(P) 770-381-9333