Georgia Prosthodontics
SMILE SPECIALISTS

Dental
Implant and
Reconstructive Center

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? _____

_____

Goal of treatment _____

_____

The following aids are available from my office:

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

Comments _____

_____

Referred by_____Office Phone _____

Date _____

Duluth: 6320 Sugarloaf Parkway - Duluth GA 30097

Buckhead: 3379 Peachtree Rd NE. Suite 830 - Atlanta GA 30326
(E) smileagain@gaprostho.com www.ImplantOption.com
(P) 770-381-9333