

Referral Form



PRECISE SMILE

Dental Implants

Socialize with Confidence

Phone: 210.587.6857

Email: services@schmittdds.com

Patient's Name: _____ Date: _____

Appointment Date/Time: _____

Referring Doctor: _____

Refer For:

- Second Opinion
- Comprehensive Care
- Limited Scope Care (in tx section)
- Call Referral Prior to Beginning Treatment
- CBCT Only (disk copy given to patient)
- Other: _____

Prosthodontic Treatment:

- | Fixed Prosthodontics | Tooth#(s) |
|--|------------------|
| <input type="checkbox"/> Functional Rehabilitation | _____ |
| <input type="checkbox"/> Esthetic Rejuvenation | _____ |
| <input type="checkbox"/> Perio/Pros Rehabilitation | _____ |
| <input type="checkbox"/> Failing Dentition | _____ |
| <input type="checkbox"/> Other: _____ | _____ |

Radiographs

- Take All Necessary
- Mailed/ Emailed
- Patient Will Bring

Maintenance

- Return for Comp Care
- Return for Hygiene Only
- Patient Released

Implant Prosthodontics

- | | Tooth# (s) |
|---|-------------------|
| <input type="checkbox"/> Single Tooth Replacement | _____ |
| <input type="checkbox"/> Multiple Tooth Replacement | _____ |
| <input type="checkbox"/> Implant Supported Dentures | _____ |
| <input type="checkbox"/> Tooth/Soft Tissue Recon. | _____ |
| <input type="checkbox"/> Malpositioned Implant Recon. | _____ |

Please Evaluate Patient For:

Condition

- Esthetic Evaluation
- Wear/Erosion
- Vertical Dimension Compromise
- Failing Fixed Prosthetics
- Rampant Caries
- Tooth Restorability
- Matching Single Central/ Anterior Tooth
- Missing Tooth/Teeth
- Dental Implant Therapy
- Fractured/ Ill-fitting Removable Prosthetic
- Sleep Apnea
- TMJ Disorder
- Oral/Maxillofacial Defect/Disorder
- Other: _____

Tooth #(s)/Area
