SMILES OF ORLANDO
CENTER FOR ADVANCED DENTISTRY

JAVIER E. MARTINEZ DDS, MS
PROSTHODONTIST

REFERRAL FAX

407656-9098

No Cover Sheet Required

REFERRED BY DR.:	REFERRING OFFICE TELEPHONE.:
INTRODUCING.:	HOME PHONE:
ALTERNATE PHONE:	INSURANCE NAME, IF ANY:

X-RAYS: **OFFICE SENDING** **PATIENT BRINGING** **TAKE AS NEEDED**

PLEASE EVALUATE FOR

Crown and Bridge
Post Perio Restoration
Occlusal Problems
Implant Rehabilitation
Esthetic Rehabilitation
Special Denture Problem
Special Partial Problem
Precision Attachment Paritals

Requires Premedication: Yes or No

Any health concerns: Yes or No

REMARKS