SMILES OF ORLANDO
CENTER FOR ADVANCED DENTISTRY

JAVIER E. MARTINEZ DDS, MS
PROSTHODONTIST

REFERRAL FAX

407656-9098

No Cover Sheet Required

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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

Collapsed Vertical Dimension
Dental Implant Rehabilitation
Occlusal Problems
TMJ/TMD
Special Denture/RPD Problem
Esthetic Rehabilitation
Crown and Bridge
Cancer/Trauma

Requires Premedication: Yes or No

Any health concerns: Yes or No

REMARKS

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