SMILES OF ORLANDO

CENTER FOR ADVANCED DENTISTRY

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REFERRAL FORM
PLEASE FAX OR EMAIL TO:

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Expert Care with Exceptional Results

Introducing: _____ Patient's Phone: _____

Referred by Dr.: _____ Dr. Phone Number: _____

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

PLEASE EVALUATE FOR

- ☐ Crown and Bridge
- ☐ Full Mouth Rehabilitation
- ☐ Occlusal Problems
- ☐ Implant Rehabilitation
- ☐ Maxillofacial Prosthestics
- ☐ Esthetic Rehabilitation
- ☐ Denture / RPD Problem
- ☐ Fractured / Loose Implant
- ☐ TMJ / TMD Evaluation
- ☐ Other - Describe below

Requires Premedication: Yes or No

Any health concerns: Yes or No

REMARKS

_____

_____

_____

TO PATIENT: Upon scheduling, our team will text or email your online registration link. Please complete your forms prior to your visit, or arrive 15 minutes early to complete them in our office. Please bring this referral slip with you to your visit. We look forward to meeting you!

ACP AMERICAN COLLEGE OF PROSTHODONTISTS Your smile. Our specialty.®

FLORIDA PROSTHODONTIC ASSOCIATION FPA 1968

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