imagine your smile
comprehensive dental associates

Office Phone number: 651-227-2427 Office Fax number 651-224-7414

**IN APPRECIATION, WE OFFER A COMPLIMENTARY CONSULTATION FOR YOUR DOCTOR REFERRAL.**

**DATE** _____

Patient's name _____ DOB _____

Patient's Phone number _____

Referring Doctor _____

Doctor's Phone Number _____

**Dental History pertaining to the current condition:**

**Referring Doctor's Preliminary Diagnosis and/or Likely Treatment discussed with your patients:**

**Relevant Diagnostic materials provided:**

- ☐ Panoramic x-ray taken within last year
- ☐ FMX
- ☐ Study Casts
- ☐ Photos
- ☐ Perio Charting

**Requested Services:**

- ☐ Extractions and Dentures
- ☐ Dentures
- ☐ Occlusal/TMJ Concerns
- ☐ Evaluation for Implants
- ☐ Sedation
- ☐ All-on-4/6 Procedure
- ☐ Esthetic Concerns

**Are there any special concerns that you would like us to consider while meeting your patient?**

**Additional Comments:**