ALEX H. KANG, DDS, MSD

FIXED & REMOVABLE PROSTHODONTICS

Specializing in Implant, Esthetic, Removable & Full Mouth Rehabilitation

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Introducing ______________________ Date ____________

Phone ______________________ E-mail ______________________

Referred by **Dr.** ______________________ Phone ____________

☐ *Would like a call back to discuss the case*

Reason for Referral

- ☐ ***ESTHETIC/COSMETIC***
- ☐ ***IMPLANT*** *prosthodontics*
- ☐ ***TMD/Parafunction***
- ☐ ***CONSULT EXAM :*** ______________________
- ☐ ***REMOVABLE*** *prosthodontics*
- ☐ ***FIXED*** *prosthodontics*
- ☐ ***MAXILLOFACIAL*** *prosthetics*

Comments ______________________

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On this patient, treatment you would like to provide

- ☐ *Extractions*
- ☐ *Hygiene maintenance*
- ☐ *Periodic exam*
- ☐ *Endodontics*
- ☐ *Periodontal therapy*
- ☐ *Other* ______________________

Available Radiographs

☐ *Periapical* ☐ *Full mouth* ☐ *Panoramic* ☐ *Other* ____________

Please fax or email a copy to our office. **THANK YOU** for the referral.