CLEARBROOK
ADVANCED DENTAL CARE

IMPLANT | ESTHETIC | RECONSTRUCTIVE DENTISTRY

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Speciality Permit # 06063

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PATIENT REFERRAL

Introducing:_____

Appointment Date & Time:_____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

Please call (609-395-9100) to schedule your patient's appointment.

This patient is being referred for evaluation of the following.

- ☐ Broken Post Tooth #____
- ☐ Esthetic Emergency - same day or next morning Tooth #____
- ☐ Extractions and Partial or Full Denture Fabrication Tooth #____
- ☐ Fractured Fixed Partial Denture {bridge} Tooth #____
- ☐ Maryland Bridge Tooth #____
- ☐ Match Single Central or other Anterior Tooth #____
- ☐ Tooth Wear with Broken Restoration(s) Tooth #____
- ☐ Sleep Apnea Appliance
- ☐ Other:_____

Complex Prosthodontic Care:

REMOVABLE PROSTHODONTICS

- ☐ Complete Denture (circle one: Upper / Lower / Both)
- ☐ Immediate / Interim Denture (circle one: Upper / Lower / Both)
- ☐ Partial Denture (circle one: Upper / Lower / Both)
- ☐ Other (specify):_____
  _____

RECONSTRUCTION

- ☐ Teeth involved #____ Utilizing:
  - ☐ Partial Coverage
  - ☐ Full Coverage
  - ☐ Veneers
- ☐ Maxillofacial Prosthesis or Appliance
- ☐ Other (specify):_____

IMPLANT PROSTHODONTICS

- ☐ Single tooth implant
- ☐ Multiple teeth implants
- ☐ Implant supported dentures
- ☐ "All on X" Prosthesis

Comments:_____

_____

☐ Please call me before proceeding with treatment. ☐ I have sent radiographs for your evaluation.

Referring Dr.:_____ Date:_____

Refering Dr. Phone #:_____