ADVANCED DENTAL RESTORATIONS

Emily Y. Chen, DDS, MA

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

Date: _____

Introducing: _____

Patient Address: _____

Primary Phone: _____ Alt. Phone: _____

Referred by: _____

Referring Dr. Phone: _____

Appointment Date: _____ Day _____ Time _____ am / pm

Recommended Treatment or Consultation Regarding:

- ❑ Full Prosthetic Evaluation
- ❑ Crowns
- ❑ Dentures
- ❑ Immediate Dentures
- ❑ Partials
- ❑ Implant Supported Prosthesis
  - ☐ Fixed ☐ Removable
- ❑ Bridges
- ❑ Sleep Apnea Appliance
- ❑ Other _____

Chief Concern: _____

Please call: ❑ Prior to Consultation ❑ After Consultation
❑ Letter Following Evaluation is Sufficient

Radiographs: ❑ Mailed /E-mailed ❑ Sent with Patient
❑ No X-Rays Available ❑ Please take

Comments or Special Instructions: _____

PLEASE FAX OR E-MAIL A COPY DIRECTLY TO THE OFFICE

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