



ADVANCED DENTAL  
RESTORATIONS

**Emily Y. Chen, DDS, MA**

Date: \_\_\_\_\_

Introducing: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

Referring Dr. Phone: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Day: \_\_\_\_\_ Time: \_\_\_\_\_ am / pm

**Recommended Treatment or Consultation Regarding:**

- |   |   |
|---|---|
| <input type="checkbox"/> Full Prosthetic Evaluation | <input type="checkbox"/> Implant Supported Prosthesis |
| <input type="checkbox"/> Crowns                     | <input type="checkbox"/> Fixed                        |
| <input type="checkbox"/> Dentures                   | <input type="checkbox"/> Removable                    |
| <input type="checkbox"/> Immediate Dentures         | <input type="checkbox"/> Sleep Apnea Appliance        |
| <input type="checkbox"/> Partials                   | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Bridges                    |   |

Chief Concern: \_\_\_\_\_

Please Call:  Prior to Consultation  Letter Following Evaluation is Sufficient  
 After Consultation

Radiographs:  Mailed / E-mailed  Send with Patient  
 No X-Rays Available  Please Take

Comments / Special Instructions: \_\_\_\_\_

**Please Fax or Email a Copy Directly to the Office**

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