INNOVATIVE DENTAL SOLUTIONS
OF SEMINOLE

PROSTHODONTICS REFERRAL FORM

Referring Dentist: _____ Phone #: _____ Fax #: _____

Patient's Name: _____ Patient's Phone #: _____

Chief Concern / Complaint: _____

Comments: _____

_____

Prosthodontic Care That May Be Required: (Check all boxes that apply to this patient)

☐ Reconstruction select One: Select One

Teeth Involved: #_____

Reconstruction needed due to: ☐ Wear ☐ Erosion ☐ Uneven Occlusal Plane ☐ Caries

☐ Other _____

Removable Prosthodontics:

☐ Complete Denture: select one: ☐ Partial Denture: select one:

☐ Immediate / Interim Denture: select one:

☐ Other (specify): _____

Fixed Prosthodontics:

☐ Crown: #_____ ☐ Bridge (fixed partial denture): _____

☐ Post and Core / Build Up: #_____ ☐ Veneer: #_____

☐ Inlay: # _____ ☐ Onlay: #_____

☐ Other (specify): _____

Implant Prosthodontics:

☐ Single Tooth Implant: #____ ☐ Multiple Teeth Implant #'s: _____

☐ Implant Supported Prosthesis

☐ Overdenture (removable): select one:

☐ Fixed Implant Supported Denture: select one:

Patient's Vertical Dimension of Occlusion is:

☐ Excessive (needs to be decreased) ☐ Reduced (needs to be increased)

Miscellaneous:

☐ Occlusion Analysis ☐ Cone Beam CT Scan ☐ Smile Design and Makeover

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Are X-rays Available? ☐ Yes ☐ No What Type? _____ Date of X-ray: _____

PLEASE FAX OR EMAIL COMPLETED FORM TO:

FAX #: 727-398-4992

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