Adam J. Geach, D.M.D., M.D.Sc. | Board Certified Prosthodontist

PATIENT REFERRAL

PLEASE FAX TO 213.622.4155

Patient's Name: _____ Date: _____

Patient's Phone #: _____

Referred by Dr. _____

Patient is referred for:

- ☐ Complete Dentures
- ☐ Overdentures
- ☐ Partial Dentures (Fixed or Removable)
- ☐ Complex Implant Restoration
- ☐ Implant Reconstruction (All-on –4, –6, –8, other)
- ☐ Complex Occlusion / Changes in VDO
- ☐ Complex Dental Needs
- ☐ Other: _____

_____

Comments: _____

_____

_____

_____

Radiographs (date of latest available):

FMX: _____ Panoramic: _____ Cone Beam CT Scan: _____

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