REFERRAL FOR ALL-ON X- IMPLANT-RETAINED DENTURES

To: Dr. Jerame Hafen, Secure Smiles at Olympia Hills Family Dental

Referring Office Information

Referring Dentist Name: _____

Practice Name: _____

Phone: _____ Fax: _____

Email: _____

Date: _____

Patient Information

Patient Name: _____

Date of Birth: _____

Primary Phone: _____

Email: _____

Address: _____

Reason for Referral

[ ] Maxillary and Mandibular [ ] Maxillary Only [ ] Mandibular Only

Medical / Dental History Summary

Edentulous? [ ] Yes [ ] No

Existing prosthesis? [ ] Yes [ ] No

Extractions done? [ ] Yes [ ] No Date of Ext: _____

Systemic conditions: _____

Medications: _____
Allergies: _____

Smoking status: [ ] Current [ ] Former [ ] Never

_____

Additional Notes / Requests _____

_____