CENTER FOR DENTAL MEDICINE & RECONSTRUCTION

PATIENT REFERRAL FORM

CDMR
Center for Dental Medicine & Reconstruction

Quinn Chan, DMD, MS, CAGS
Specialist in Prosthodontics & Dental Reconstruction

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Specialist in Periodontics & Implant Dentistry
Diplomat, American Board of Periodontlogy & Implant Surgery

PATIENT REFERRED

Name _____ Date _____

Phone _____ E-mail _____

REFERRING DOCTOR

Name _____ Practice _____

Phone _____ E-mail _____

Specialty (please check one):

( ) Oral Surgery ( ) Periodontics ( ) Endodontics ( ) Orthodontics ( ) General Dentistry ( ) E.N.T ( ) P.C.P ( ) Other_____

REASON FOR REFERRAL (Please Check All Applicable)

PROSTHODONTICS

( ) Comprehensive Prosthodontic Evaluation
( ) Limited Prosthodontic Evaluation (Please Elaborate Below)
( ) Implant Prosthodontics:
  ( ) Full Arch Implant Bridge ( ) Partial Implant Bridge
  ( ) Single Implant Crown ( ) Implant Temporization
  ( ) Implant Overdenture ( ) Implant Over Partial Denture
  ( ) Broken Abutment/Screw ( ) Other (Please Elaborate Below)

Please Provide Type, Size, and Date of Placement of Implant(s) To Be Restored: _____

( ) Crown and Bridge:
  ( ) Full Arch / Loss of VDO ( ) Smile Analysis and Treatment
  ( ) Partial Bridge ( ) Other (Please Elaborate Below)
( ) Removable Prosthodontics:
  ( ) Complete Denture ( ) Partial Denture
( ) Temporomandibular Disorder

PERIODONTICS

( ) Comprehensive Periodontal Evaluation
( ) Implant Placement: Tooth #(s) _____
( ) Esthetic Crown Lengthening
( ) Pre-Prosthetic Crown Lengthening
( ) Gingival Recession
( ) Soft tissue Correction/Enhancement
( ) Frenum Involvement: Tooth #(s) _____
  ( ) Buccal ( ) Lingual
( ) Periodontal Regeneration
( ) Ridge Augmentation
( ) Sinus Elevation
  ( ) UR ( ) UL ( ) Both
( ) Extraction: Tooth #(s) _____
( ) Socket / Ridge Preservation

Periodontal Treatment(s) Completed in your Office:

( ) Prophylaxis: Date Last Completed _____
( ) Full Mouth Debridement: Date Last Completed _____
( ) SCRP: Date Last Completed _____
  ( ) UR ( ) UL ( ) LR ( ) LL

OTHER

( ) Radiographs:
  ( ) Panoramic ( ) Cone Beam CT

Radiographs: ( ) Enclosed ( ) E-mailed (Preferred) ( ) Mailed ( ) Patient will Bring ( ) Please Take as Necessary

( ) Please Contact Me Prior to Proceeding with Treatment (Best Phone #/ E-mail: _____)

Comments: _____

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