HOUSTON PROSTHODONTIC SPECIALISTS

Date: _____

Referring Office & Doctor's Name: _____

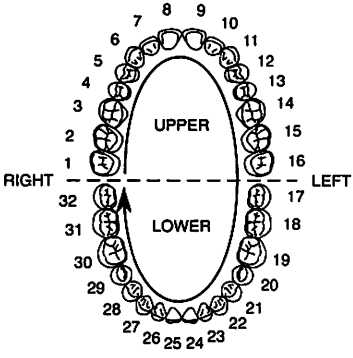
_____

Email / Office Phone Number: _____

_____

Patient Name: _____ DOB: _____

I am referring this patient for:



- ☐ Implant Only
- ☐ Implant & Restoration
- ☐ Full Mouth Rehabilitation
- ☐ Hybrid / Overdentures / All on 4
- ☐ Traditional / Partial Dentures
- ☐ Occlusal Guard / Sleep Apnea Appliance
- ☐ Localized Treatment of: (explain in comments)

Comments / Special Concerns: _____

_____

_____

_____

_____

Patient Records (mark all that apply):

- ☐ Radiographs
- ☐ CT Scan (CD or USB Thumb Drive)
- ☐ Procedure Notes
- ☐ Diagnostic Cast or Impression

Doctor Preference:

- ☐ Dr. Xavier Saab
- ☐ Dr. Ricardo Cisneros
- ☐ Dr. B. Peter El-Dahdah
- ☐ Dr. Dimitri Haber

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