Bedford Center for Prosthodontics

Smile Design Excellence

262 SOUTH RIVER ROAD • BEDFORD, NH 03110 • (603) 625-6456

PATIENT REFERRAL

Introducing: _____

Appointment Date & Time: _____

Please bring this form to your appointment.

Please call (603) 625-6456 to schedule your patient's appointment.

This patient is being referred for evaluation of the following:

REMOVABLE PROSTHESIS

☐ Complete Denture
(circle one: Upper / Lower / Both)

☐ Immediate
(circle one: Upper / Lower / Both)

☐ Partial Denture
(circle one: Upper / Lower / Both)

RECONSTRUCTION

☐ Smile Makeover / Aesthetics

☐ Worn Dentition

☐ Missing Teeth

IMPLANT PROSTHODONTICS

☐ Single Tooth Implant

☐ Multiple Teeth Implants

☐ Implant Supported Dentures

- ☐ Removable
- ☐ Fixed

Comments: _____

_____

_____

_____

_____

_____

☐ Please call me before proceeding with treatment. ☐ I have sent radiographs for your evaluation.

Referring Dr.: _____ **Date:** _____

Referring Dr. Phone #: _____