



SUMMIT DENTAL STUDIO

REFERRAL FORM

(Please complete and send with patient or email to our office
info@summit-dentalstudio.com)

Referring Office: _____

Referring Doctor: _____

Office Phone: _____ Fax: _____

Email: _____

Patient Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Email: _____

INDICATE REASON FOR REFERRAL:

SEDATION

- IV moderate sedation
- Nitrous Oxide/Oral Sedation

IMPLANTOLOGY

- Esthetic zone implants
- Posterior implants
- Full arch implants (All-on-X)
- Remote anchorage implants

CLINICAL NOTES/SPECIAL INSTRUCTIONS

PROSTHODONTICS

- Fixed hybrid dentures (FP1 and FP3)
- Removable overdentures
- Conventional dentures

ORAL SURGERY/PERIODONTICS

- Extractions: _____
- Soft tissue grafting (FGG/CTG)
- Sinus lift/advanced bone grafting

ENDODONTICS

- Tooth: _____

CASE PLANNING

- CBCT capture
- Treatment planning
- In house travel surgery

LOCATION : 8051 WASHINGTON VILLAGE DR, UNIT B, DAYTON, OH 45458

PHONE : (937) 977-1818

WEBSITE : SUMMIT-DENTALSTUDIO.COM