Referring Dentist's Name: _____ Date: _____

Dentist's Phone: _____ Fax: _____

Patient's Name: _____ Phone: _____

Chief Concern or Complaint: _____

Past Dental History: _____

Special Concerns: _____

Prosthodontic Care That May Be Required: (check the boxes that apply for this patient)

Removable Prosthodontics:

- ☐ Complete denture ☐ upper ☐ lower ☐ both
- ☐ Partial denture ☐ upper ☐ lower ☐ both
- ☐ Immediate/interim denture ☐ upper ☐ lower ☐ both
- ☐ Overdenture ☐ upper ☐ lower ☐ both
- ☐ Emergency
  - ☐ Broken denture base
  - ☐ Broken denture tooth
  - ☐ Broken clasp
- ☐ Reline to existing denture
- ☐ Other (specify): _____

Fixed Prosthodontics:

- ☐ Crown # _____ ☐ Bridge (fixed partial denture) # _____
- ☐ Veneer # _____ ☐ Post & core or build-up # _____
- ☐ Inlay # _____ ☐ Onlay # _____
- ☐ Emergency (specify) _____
- ☐ Other (specify) _____

Implant Prosthodontics:

- ☐ Single tooth implant # _____ ☐ Implant supported dentures _____
- ☐ Multiple teeth implants #'s _____

Reconstruction:

- ☐ Full-mouth ☐ Partial-mouth
- ☐ Teeth involved # _____

Patient's vertical dimension of occlusion is:

- ☐ Excessive (needs to be decreased) ☐ Reduced (needs to be increased)

DAY DATE TIME

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Board Certified Prosthodontist

PRO dental DALLAS

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