

**Abhay Bedi, B.D.S., D.M.D., M.S.**  
*PRACTICE LIMITED TO PROSTHODONTICS*

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Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Referring Dr: \_\_\_\_\_

Phone: \_\_\_\_\_

***How may we assist your patient and you in the treatment of your patient?***

( ) Please examine completely and comprehensively treatment plan

( ) Localized Focus: \_\_\_\_\_

\_\_\_\_\_

Most recent FMX taken on: \_\_\_\_\_ Panoramic on: \_\_\_\_\_

Please check all that apply:

( ) Please take necessary radiographs

( ) FMX will be supplied via mail

( ) FMX will be brought to consultation by patient

( ) Please call our office

( ) Prosthetic/restorative plans, comments, concerns, case description

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