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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

