HERITAGE DENTAL GROUP
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Date: _____ **Referring Doctor's Name:** _____

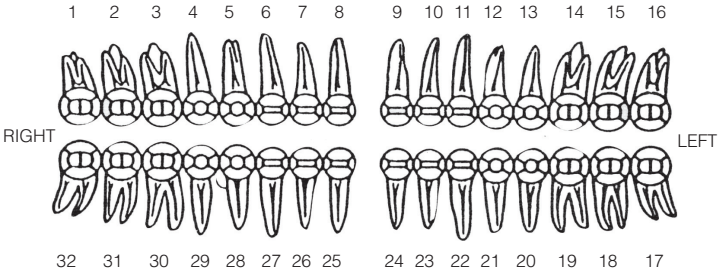
Address: _____ Phone: _____

Introducing: _____

To Heritage Dental Group for the following treatment: _____

_____

Please indicate reason for visit and circle the teeth involved:



Referral for (please indicate below):

- ☐ Full Mouth Reconstruction
- ☐ Dental Implants
- ☐ Esthetic Evaluation
- ☐ Fixed Prosthodontics
- ☐ Removable Prosthodontics
- ☐ Other: _____

Chief Concern: _____

Additional Comments: _____

_____

Radiographs:

- ☐ Emailed (preferred)
- ☐ Sent with patient
- ☐ Enclosed
- ☐ Please take

Preferred Consultation Report:

- ☐ In Writing
- ☐ Phone
- ☐ Mail
- ☐ Email