Tracy L Boldry, D.M.D., M.S.

Prosthodontics

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Prosthodontic Consultation Referral Information

Referring Doctor Information

Please email current patient radiographs to perfectsmilesdc@gmail.com

Name:

Address: _____

Phone: _____ **Email:** _____

Patient Information

Name: _____
(First) (Middle Initial) (Last)

Address: _____
(Street and Number) (Apt/Unit #)

_____
(City) (State) (Zip)

Phone: _____
(Home) (Mobile) (Work)

Email: _____

Current Prosthetic Appliances: _____

Reason for Referral (circle)

DENTURE(S):

COMPLETE	Upper	/	Lower
IMPLANT SUPPORTED DENTURE(S)	Upper	/	Lower
IMMEDIATE	Upper	/	Lower

REMOVEABLE PARTIAL DENTURE(S):

METAL BASED	Upper	/	Lower
IMPLANT RETAINED METAL BASE RPD	Upper	/	Lower

CROWN(S) / BRIDGE(S): Area _____

IMPLANTS: Site(s) _____

FULL MOUTH REHABILITATION: _____

TMJ DISORDER / PAIN: _____

COSMETIC CONCERN: _____

FURTHER INSTRUCTIONS: _____

We greatly appreciate the confidence you show in our practice by the referral of your patient.

Sincerely, The Perfect Smiles Dental Care Team