IMPLANT DENTISTRY
NORTHWEST
www.ImplantDentistryNW.com

Keith Phillips
DMD, MSD, CDT, FACP
5619 Valley Avenue East
Tacoma, WA 98424
Phone: (253) 922-5519
Fax: (888) 653-3484
Email:Info@ImplantDentistryNW.com

Introducing: _____ Date: _____

Patient Phone: _____ Patient DOB: _____

◯ Patient will call ◯ Please call patient for appointment

Referring Doctor: _____ Phone: _____

REASON FOR REFERRAL

◯ Prosthodontic Treatment Only
◯ Surgical Treatment
◯ Surgical and Prosthodontic Treatment

TOOTH/AREA FOR EVALUATION:

_____
_____
_____

SPECIFIC CONSIDERATIONS

Implant:
◯ Fixture Placement
◯ Restoration
◯ I-CAT
◯ All on 4

Prosthodontics:
◯ Crown/Veneer(s)
◯ Fixed Bridge
◯ Partial Denture
◯ Complete Denture

RECENT RADIOGRAPHS (Please Email)

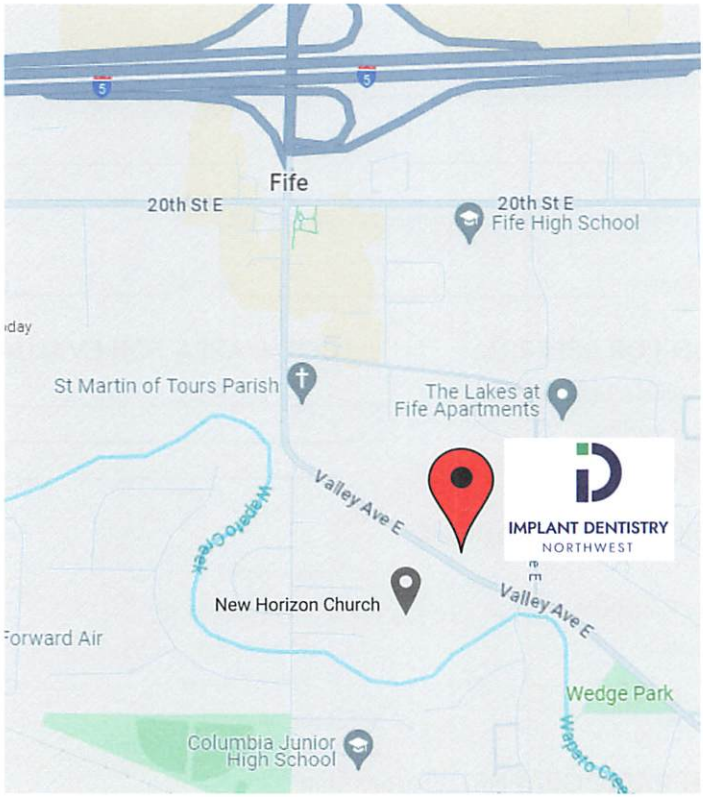
◯ Please take new Radiographs
◯ Attached with this referral
◯ Mailed to your office

CASE NOTES:

_____
_____
_____
_____
_____

INSTRUCTIONS FOR FIRST VISIT:

1. Please bring this form to your appointment
2. Payment is due at the time of treatment unless other arrangements have been made in advance
3. Before your visit, please visit the link in your email to fill out your patient registration.



5619 Valley Ave East
Tacoma, WA 98424

Email: Info@ImplantDentistryNW.com
Website: www.ImplantDentistryNW.com