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Referral and Treatment Request

Today's Date ____________________

Patient's Name ____ Date of Birth ____________________

Patient's Phone Number ____

Patient's Email Address ____

How would the patient like to be contacted to schedule?

☐ Phone Call ☐ Text Message ☐ Email ☐ Patient will contact Sioux Falls Dental Implant Center

Referring Dentist ____

Treatment Requested (Please check all that apply)

☐ **Single tooth implant(s) to replace tooth number(s):** ____

- ☐ I prefer to have case back in healing cap(s)
- ☐ I prefer to have case back in abutment(s)/temporary crown(s)
- ☐ Please complete the case including final crown(s)

☐ **Denture Stabilization/Implants for Removable:** ☐ Maxillary ☐ Mandibular

- ☐ I prefer to fabricate new denture(s) for this patient
- ☐ Please fabricate new denture(s) as required

☐ **Full Arch Fixed/All-on-X:** ☐ Maxillary ☐ Mandibular

- ☐ I prefer to have case back in immediate temporary prosthetics
- ☐ Please complete the case including final prosthetics

☐ **Other services requested:**

- ☐ IV Sedation
- ☐ Extraction tooth number(s): ____
- ☐ Wisdom tooth removal: ____
- ☐ Bone grafting: ____
- ☐ Other: ____