Sioux Falls
Dental Implant Center

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Referral and Treatment Request

Today's Date _____

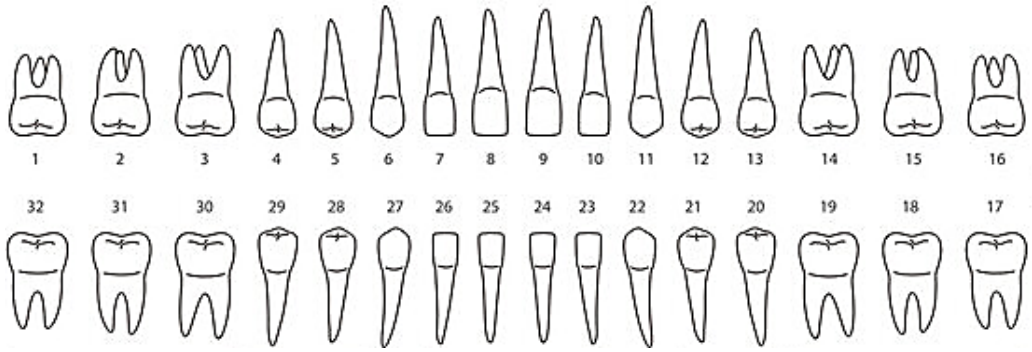
Patient's Name _____ Date of Birth _____

Patient's Phone Number _____

☐ Please Contact Patient ☐ 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

☐ **IV Sedation**

☐ **Extraction tooth number(s):** _____

☐ **Wisdom tooth removal:** _____

☐ **Bone grafting:** _____

☐ **Other:** _____