



Date: \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_

Please schedule Mr./ Ms. \_\_\_\_\_ for an evaluation with

**Dr. Paola Sugajara - Prosthodontist**

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Referring Doctor: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Website: \_\_\_\_\_

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Doctor's comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you like to be notified before proceeding with treatment(s)?  Yes  No

How would you like to be notified?  Fax  Email  Mail  Phone

3D CBCT image requested?  Yes  No

715 Pendleton St., Alexandria, VA 22314 | P: 571-970-3783 | F: 571-970-3827

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