FOUNTAINGROVE DENTISTRY

Ulf Temnitzer, DDS - Prosthodontist

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Patient Name**:** _____Date**:** _____

Patient Phone Number: _____

Referring Doctor**:** _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Radiographs- ☐ Emailed ☐ No current series

CBCT available- ☐Sent w/ patient ☐Mailed ☐ Not Available

Implant Specifications: _____

REFERRED FOR:

☐ Complete Exam and Treatment

☐ Limited Prosthodontic Evaluation

☐ Crown and Bridge/Fixed

☐ Implant Reconstruction

☐ Other_____

☐ Removable Appliance

☐ Denture Repair

☐ Occlusal Evaluation

☐ Cosmetic Dentistry

Notes:

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