

FOUNTAINGROVE DENTISTRY



Ulf Temnitzer, DDS - Prosthodontist

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Referral date: _____

Patient Name: _____ DOB: _____

Patient Phone Number: _____

Referring Doctor: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Radiographs- FMX dated _____ BW dated: _____

No current series Please take X-rays

CBCT File- Sent w/ patient Mailed to FGD Not Available

Implant Specifications (Brand, size, placement date): _____

REFERRED FOR:

Complete Exam and Treatment

Removable Appliance

Crown and Bridge

Fixed Appliance

Denture Repair

Implant Reconstruction

Cosmetic Dentistry

All-On-X

Other: _____

Notes: