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Dr. Faisal Al Assadi
Certified Specialist in **PROSTHODONTICS**

Prosthodontic Referral Form

Today's Date: (MMM DD, YYYY) ________________

Patient name: (Ms. Miss. Mrs. Mr. Dr.) ______________________________

D.O.B (MMM DD, YYYY): ______________________________

Home Phone: ( ) ______________ Cellular Phone: ( ) ______________

E-mail: ______________________________

Referral Details (Please ☒ check or circle the reason(s) for referral)

☐ Complete Prosthodontic care ☐ Dental Implants ☐ Crown & Bridge ☐ Removable Dentures

☐ Other or limited prosthodontic care (please explain): ______________________________

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Radiographs included: ☐ Bitewings ☐ Periapicals ☐ Panoramic ☐ Other: ______________

Study casts included: ☐ yes ☐ no CBCT Scan Records: ☐ yes ☐ no

Referring Dentist: ______________________ Phone: ( ) ______________

Address: ______________________ Fax: ( ) ______________

______________________ Email: ______________

Requested Report by: ☐ Telephone ☐ Letter ☐ E-mail