Turlock
Oral & Maxillofacial Surgery

1810 N. Olive Ave., Suite #6, Turlock, CA 95382
Phone: (209) 667-5050

IMPLANT CONSULTATION REQUEST

Please FAX to 209-667-7559

RESTORATIVE DOCTOR ⟶ Turlock Oral & Maxillofacial Surgery

Date: _____

We are referring _____ to your office for a surgical evaluation for dental implant placement. We have developed a tentative treatment plan illustrated below.

Number of Implants: _____

Location of Implants: _____

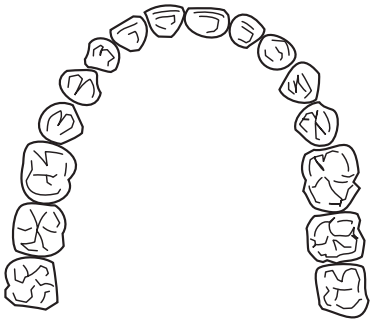
☐ Single Tooth Implant

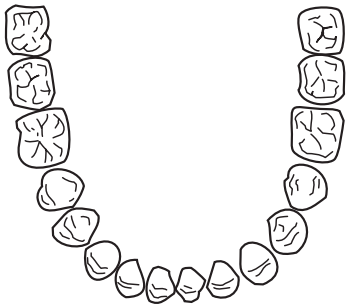
☐ Fixed Prosthesis

☐ Removable Prosthesis — ☐ Bar / Clip ☐ Ball / Socket

Legend: ● Implant

✖ Extraction of Tooth





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☐ Please call me or arrange a meeting to discuss this case further

Already discussed with patient:

☐ Restorative Costs $ _____

☐ Potential for bone grafting _____

☐ Type of interim prosthesis _____

☐ No provisional planned

☐ Expected treatment time _____

☐ Expected healing time w/o prosthesis _____

☐ Option of extracting teeth with immediate implantation

System Preferred:

☐ Astra

☐ _____

Please report your findings as soon as you can. In the event you need a prosthetic stent, please let us know. Don't hesitate to contact me or my Treatment Coordinator, _____ with any questions.

Sincerely,

Dr. _____