

IMPLANT CONSULTATION REQUEST

Please FAX to 209-667-7559

RESTORATIVE DOCTOR \longrightarrow 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: _____

Legend: ● Implant

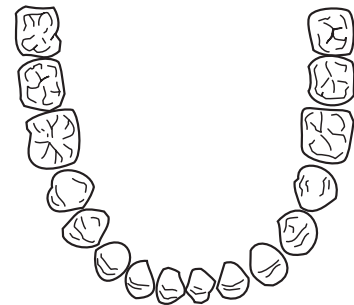
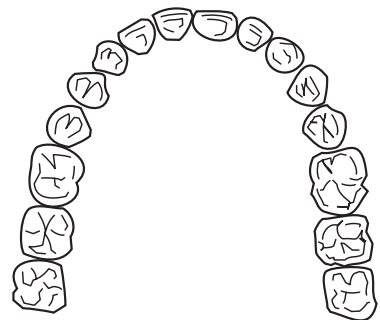
Location of Implants: _____

✕ Extraction of Tooth

Single Tooth Implant

Fixed Prosthesis

Removable Prosthesis — Bar / Clip Ball / Socket



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. _____