Dr. Michael Yeh, DDS, MSD

Implant Surgeon & Prosthodontist

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PRIMARY INFORMATION

REFERRED BY DR.	DATE
PATIENT NAME	DATE OF BIRTH
PATIENT'S HOME	PATIENT'S CELL

REFERRAL INFORMATION

Patient is referred for (check all that apply)

- ◯ Full Mouth Restoration
- ◯ Crown/Fixed Bridge
- ◯ Veneers
- ◯ Complete/Partial Dentures
- ◯ Sinus Lift
- ◯ Bone Graft
- ◯ Extraction
- ◯ Implant Placement
- ◯ Implant Restoration
- ◯ All-on-X

COMMENTS

Please indicate treatment alternatives that have been discussed and additional information regarding management, medical conditions, etc. Thank you!

RECORDS AVAILABLE

- ◯ RADIOGRAPHS
- ◯ PERIOCHART
- ◯ PICTURES

Please forward any pictures and/or radiographs to **ldcxray@hotmail.com**
or have patient to bring a copy of their records