QUALITY DENTURES & IMPLANTS
North Jacksonville, FL

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REFERRAL FOR EXTRACTIONS / DENTURES / IMPLANTS

Patient Name: _______________________________ Phone:_______________________ Today's Date: _____________

Pt being referred to Quality Dentures and Implants for the following treatment:___________________________________

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Extractions Sites:

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
R	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	L

Dentures/ Partial Dentures: ____

Implant Sites (Neodent system):____

Remarks: ____

Additional Medical History that may affect dental surgery:____

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____Medication List Attached

Referring Doctor:

Physician Name (Please print):____ Tel:________________________________

Physician Signature:____ Date:________________________________

We appreciate your assistance in providing optimum care for this patient. Please have Physician sign and send back to Quality Dentures either by fax: 904-518-6163 or email to Office@qualitydenturesfl.com or have the patient bring it with them to their first appointment.