LEADING EDGE
SPECIALIZED DENTISTRY

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Springfield, NJ 07081

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LeadingEdgeSpecializedDentistry.com

Date: _____

Patient's Name: _____

Phone (Home): _____ (Business): _____

Referring Dentist: _____

REFERRAL REQUESTED

- ☐ EXTRACTION
- ☐ EXPOSURE
- ☐ IMPLANTS
- ☐ ORAL PATHOLOGY
- ☐ ROOT CANAL
- ☐ TMJ EVALUATION
- ☐ GRAFTING PROCEDURES
- ☐ OTHER

REMARKS _____

				A	B	C	D	E	F	G	H	I	J			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R																L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
				T	S	R	Q	P	O	N	M	L	K			

X-Rays being sent _____ BWX _____ FMX _____ PAN

- ☐ I have not as yet proposed a definitive restorative treatment plan to the patient.
- ☐ I have tentatively proposed the following treatment plan to the patient. Please evaluate the circled teeth as possible abutments for (fixed) or (removable) prosthetics.

NOTE: General anesthesia patients must abstain from food and liquids for at least 8 hours prior to appointment. They should be accompanied by an adult and not operate a motor vehicle.