CENTERPOINT
ADVANCED RESTORATIVE
& ESTHETIC DENTISTRY

CATHARINE M. KWON, DDS, MSD
PROSTHODONTIST

PROSTHODONTICS REFERRAL FORM

Referring Dentist: _____ Phone #: _____ Fax #: _____

Patient's Name: _____ Patient's Phone #: _____

Chief Concern / Complaint: _____

Past Dental History: _____

Special Concerns: _____

Prosthodontic Care That May Be Required: (Check all boxes that apply to this patient)

Removable Prosthodontics:

☐ Complete Denture: (circle one: upper / lower / both) ☐ Partial Denture: (circle one: upper / lower / both)

☐ Immediate / Interim Denture: (circle one: upper / lower / both) ☐ Overdenture: (circle one: upper / lower / both)

☐ Emergency:

☐ Broken Denture Base ☐ Broken Denture Tooth ☐ Broken Clasp

☐ Reline to Existing Denture

☐ Other (specify): _____

Fixed Prosthodontics:

☐ Crown: #_____ ☐ Bridge (fixed partial denture): _____

☐ Post and Core / Build Up: #_____ ☐ Veneer: #_____

☐ Inlay: # _____ ☐ Onlay: #_____

☐ Emergency (specify): _____

☐ Other (specify): _____

Implant Prosthodontics:

☐ Single Tooth Implant: #____ ☐ Multiple Teeth Implant #'s: _____ ☐ Implant Supported Dentures

Reconstruction (Circle One: Full-Mouth / Partial Mouth):

☐ Teeth Involved: #_____

Patient's Vertical Dimension of Occlusion is:

☐ Excessive (needs to be decreased) ☐ Reduced (needs to be increased)

Miscellaneous:

☐ Demanding Patient (give brief history): _____

☐ TMD Complaint (give brief history): _____

PLEASE FAX OR EMAIL COMPLETED FORM TO:

FAX #: 972-480-0900

CAREDENTISTRYTX@GMAIL.COM

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