PROSTHODONTICS

CERTIFIED SPECIALISTS
IMPLANT, AESTHETIC & RECONSTRUCTIVE DENTISTRY

PROSTHODONTISTS

◯ Dr. Oliver C. Pin-Harry ◯ Dr. Michael Yang ◯ First available

DATE

_____ / _____ / _____
Month Day Year

PATIENT INFORMATION

Introducing _____

PATIENT'S DATE OF BIRTH

_____ / _____ / _____
Month Day Year

CONTACT

Home _____
Work _____
Mobile _____
Email _____

PREFERRED METHOD OF CONTACT

◯ Home ◯ Mobile
◯ Work ◯ Email

APPOINTMENT

◯ Already scheduled ◯ Please contact patient ◯ Patient will contact your office

CONSULTATION REGARDING

_____
_____
_____

SIGNIFICANT MEDICAL & DENTAL HISTORY

_____
_____
_____

RADIOGRAPHS

◯ Emailed (preferred) info@tprosthodontics.com
◯ Enclosed
◯ Mailed
◯ With patient
◯ None

CONSULTATION REPORT

◯ In writing
◯ Email to _____

REFERRED BY DR. _____

DR.'S SIGNATURE _____

THE FOLLOWING APPOINTMENT HAS BEEN RESERVED FOR YOU

Please be advised 2 business days are required for any changes to avoid cancellation fees.

DATE _____ / _____ / _____
Month Day Year

TIME _____

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