PUGET SOUND
ADVANCED
DENTISTRY

Date: ______________________________

Patient Name: ____

Home Phone: _________________________ Work Phone:___________________________

Referring Doctor: ____

CONSULTATION

_____ to have consultation only

_____ to have Prosthodontist do complete treatment

_____ to have Prosthodontist do specified treatment only

Consultation and/or treatment requested: _____________________________________

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APPOINTMENT

DAY______________________ DATE________________________ TIME___________________

Enclosed (or e-mailed): X-rays _____ Charting _____ Photos _____

Please send referral and x-rays to: ellen@schmidtadvanceddentistry.com.

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