Platt Prosthodontics

Board Certified Prosthodontists

Date_____

Patient's Name_____ DOB _____

Phone_____ Alt _____

Email _____

Address _____

_____

Referring Doctor _____

Phone _____

Email _____

Referring to: ❑ Shawn P. Platt DMD, FACP ❑ Brandon M. Wilburn DMD, FACP ❑ First Available

Reason for Referral:

- ❑ Full-mouth Rehabilitation
- ❑ Fixed Prosthodontics
- ❑ Implant Prosthodontics
- ❑ Removable Prosthodontics
- ❑ Maxillofacial Prosthetics
- ❑ Aesthetic Rehabilitation
- ❑ Challenging Anterior Restoration
- ❑ Occlusion
- ❑ TMD
- ❑ Second Opinion
- ❑ Other_____

Sending: ❑ FMX_____ ❑ PA_____ ❑ Pano_____ ❑ CBCT_____ ❑ Chart Notes

Please provide continuing care for this patient : ❑ Yes ❑ No

Comments/Patient Concerns or Goals:_____

_____

_____

_____

1300 Esther Street, Suite 101 • Vancouver, WA 98660

Tel 360-693-4701 • Fax 360-993-5299

drplatt@plattprosthodontics.com

Please send referrals, imaging and insurance information to the email address above.