



ANDREW FERRIER, DDS



REFERRAL TO PROSTHODONTIST

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____

PATIENT PHONE: _____ ALT PHONE: _____

REFERRING DENTIST: _____ PHONE: _____

CHIEF CONCERN OR COMPLAINT: _____

SPECIAL CONSIDERATIONS: _____

REASON FOR REFERRAL

- Implant Dentistry: _____
- Cosmetic Dentistry: _____
- Fixed Prosthodontics: _____
- Reconstruction: _____
- Crown and Bridge: _____
- Removable: _____

SURGICAL TREATMENT:

- Pending
- Implant Surgery Scheduled Date: _____
- Implant Surgery Completed Date: _____

IMPLANTS PLACED:

Tooth Number(s): _____

Type: _____

Size : _____

895 Moraga Road #11
 Lafayette, CA 94549
 Tel: 925-283-0313
 Fax: 925-283-6818
 office@EastBayHealthySmiles.com

2020 Hearst Avenue
 Berkeley, CA 94709
 Tel: 510-841-0662
 Fax: 510-841-0917
 EBHSBerkeley@gmail.com

Please send a copy of this referral and any x-rays to our office.

www.EastBayHealthySmiles.com