Center for Dental Implants of South Florida
ARUN K. GARG, D.M.D.

# Referral Form

| PATIENT INFORMATION | |
|---|---|
| Date: | Month Day Year |
| First Name: | |
| Last Name: | |
| Telephone: | |
| **REFERRING DOCTOR INFORMATION** | |
| Referred By: | |
| Telephone: | |
| Email: | |

| CONSULTATION and/or PROCEDURE |
|---|
| ☐ Pre-Prosthetic |
| ☐ Implants |
| ☐ Soft Tissue Grafting |
| ☐ General Bone Grafting |
| ☐ Maxillary Sinus Grafting |
| ☐ Anterior Maxilla Grafting |
| ☐ Additional Width required for Posterior Mandible |
| ☐ Additional Height required for Posterior Mandible |
| ☐ Removal of Implant(s) |
| ☐ Please plan to perform the grafting and my office will place the implants and perform the prosthetic phase |
| ☐ Please plan to perform the grafting and place the implants and my office will perform the prosthetic phase |
| ☐ Please plan to perform the grafting and place the implants. Please have your restoring doctor perform the prosthetic phase and return to my office for general dentistry and continued follow up. |

| RADIOGRAPHS OR CLINICAL PHOTOS |
|---|

Center for Dental Implants
of South Florida
ARUN K. GARG, D.M.D.

- ☐ Being Mailed
- ☐ Given to Patient
- ☐ Please Take
- ☐ No X-Ray

COMMENTS

2999 NE 191ST STREET SUITE 210 AVENTURA, FLORIDA 33180