Alfredo Montes, DDS, MS

Specialist in Prosthodontics

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Date ______________________________

Patient Name ______________________________

Phone ______________________________

For:

- ❑ Dental Implant Evaluation and Treatment
- ❑ Cosmetic Evaluation
- ❑ Removable Prosthetics
- ❑ Full Coverage Restoration(s)
- ❑ Occlusal Considerations
- ❑ Altered Vertical Dimension
- ❑ Parafunctional Clenching/ Grinding

Remarks: ______________________________

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Inclusions:

❑ Radiographs ❑ Models ❑ Progress Notes

Appointment Date ______________ Time ______________

Referring Doctor ______________________________

Referring Practice ______________________________

Email ______________________________

Phone ______________________________

Fax ______________________________