

# Alfredo Montes, DDS, MS

*Specialist in Prosthodontics*

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Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

- For:
- |  |   |
|--|---|
| <input type="checkbox"/> Dental Implant Evaluation and Treatment | <input type="checkbox"/> Occlusal Considerations            |
| <input type="checkbox"/> Cosmetic Evaluation                     | <input type="checkbox"/> Altered Vertical Dimension         |
| <input type="checkbox"/> Removable Prosthetics                   | <input type="checkbox"/> Parafunctional Clenching/ Grinding |
| <input type="checkbox"/> Full Coverage Restoration(s)            |   |

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Inclusions:

- Radiographs       Models       Progress Notes

Appointment Date \_\_\_\_\_ Time \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Referring Practice \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

