IMPLANT CONSULTATION REQUEST

Please FAX to 209-527-0659

RESTORATIVE DOCTOR → DRS. BAKER & CADRA

Date: ______________________________

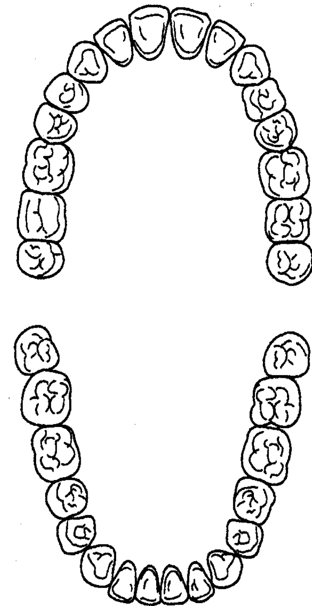
We are referring ____________________________ to your office for a surgical evaluation for dental implant placement. We have developed a tentative treatment plan illustrated below.

Number of Implants: ____________________________________

Location of implants ____________________________________

Legend • = Implant
x = Extraction of tooth

- ☐ Single Tooth Implant
- ☐ Fixed Prosthesis
- ☐ Removable Prosthesis
  - ☐ Bar/Clip
  - ☐ Ball/Socket



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☐ Please call me or arrange a meeting to discuss this case further

Already discussed With Patient:

- ☐ Restorative Costs ___ $ ______________________________
- ☐ Potential for bone grafting ______________________________
- ☐ Type of Interim Prosthesis ______________________________
  - ☐ No Provisional Planned
- ☐ Expected Treatment Time ______________________________
- ☐ Expected Healing Time w/o prosthesis ____________________
- ☐ Option of extracting teeth with immediate implantation

System Preferred

- ☐ Astra
- ☐ ________________

Please report your findings as soon as you can. In the event you need a prosthetic stent, please let us know.

Don’t hesitate to contact me or my Treatment Coordinator, ________________________ with any questions.

Sincerely,

Dr. ___________________________________