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First Available Appointment

www.BernardoCenterDentistry.com
Office@bernardocenterdentistry.com

Send more referral slips.

Board Certified Specialist in Prosthodontics

Referring Doctor's Name: _____ Date: _____

Office Phone: _____

Office Email: _____

Please send me a consultation report by: Email Mail Phone call

Patient's Name: _____

Phone: (h) (c) _____

Email: _____

Radiographs

WITH PATIENT

EMAILED

TAKE NEW

NONE

DATE TAKEN: _____

***Preferred Method:** Our office to call and schedule patient.

Patient will call to schedule appointment

Need our office to contact your office first.

Medical Alert: _____

REFERRED FOR:

Premed patient

Complex Prosthodontic Evaluation

Limited Prosthodontic Consultation

Aesthetic Evaluation or Consultation

Implant Prosthodontics/ Reconstruction

Dentures (Traditional or Overdenture)

Unknown Implant or broken component

Removable Partial Dentures (RPD)

Sleep Apnea evaluation / Treatment

Pre-radiation or Joint Replacement evaluation

TMJ / TMD Evaluation / Bite or Occlusion

Comments: _____

Please email: office@bernardocenterdentistry.com or Fax: 858.487.6717

White copy — Patient copy; Yellow copy — Office copy for your records

Thank you!

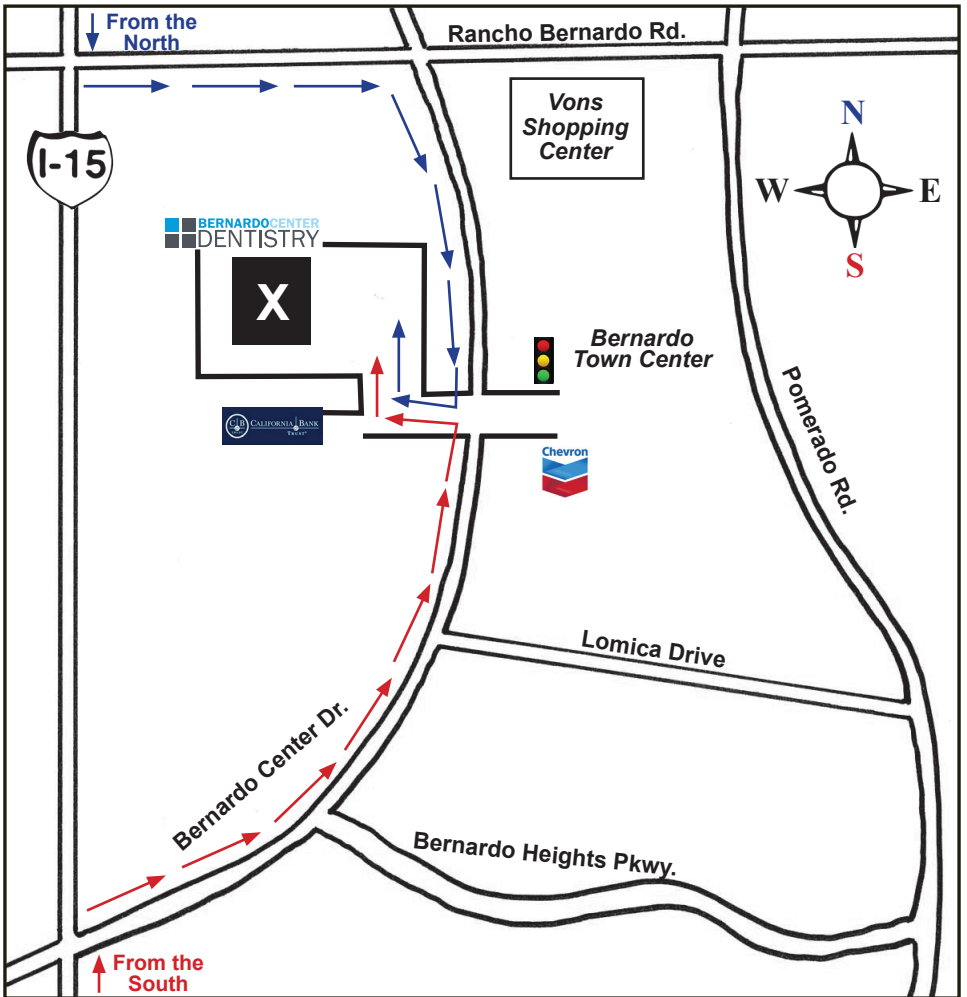
Our Location

16816 Bernardo Center Drive, Suite 200 (2nd floor)

San Diego, CA 92128

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We look forward to serving you.