ICUSMILE™
SPECIALTY CLINIC

Aesthetic Dentistry & Oral Rehabilitation
Limited to Prosthodontics

Myra Brennan, DMD
Board Eligible, American College of Prosthodontists

REFERRAL FOR PROSTHODONTIC CONSULTATION

Date: _____

Patient Information

Name: _____

Telephone: _____

Email: _____

Referring Doctor:

Name: _____

Telephone: _____

Email: _____

Referral for Specialty Consultation (Check all that apply)

- ○ Esthetic Restoration of the Smile
- ○ Esthetic Restoration of a Front Tooth
- ○ Implant Fixed Restoration
  - ○ Singe Tooth
  - ○ Partial Arch
  - ○ Full Arch
- ○ Implant Removable Restoration
  - ○ Partial Arch
  - ○ Full Arch
- ○ Evaluation for Worn Dentition
- ○ Evaluation for Posterior Bite Collapse/Malocculsion
- ○ Evaluation for Failing Restorations/Prosthesis

TEETH IN QUESTION:

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Additional Notes: _____

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