



MIDWEST CENTER FOR DENTISTRY AND IMPLANTS

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PATIENT INFORMATION

Patient name _____ Date of birth _____

Phone _____ Email _____

REFERRING OFFICE

Referring dentist _____ Practice name _____

Office phone _____ Office fax _____ Email _____

REASON FOR REFERRAL / TOOTH NUMBER(S)

REQUESTED SERVICES

- | | |
|---|---|
| ☐ Implant evaluation (3D CBCT) | ☐ Full-arch implant treatment (fixed or removable) |
| ☐ Single or multiple implant placement | ☐ Sinus lift |
| ☐ Extraction | ☐ Wisdom tooth evaluation |
| ☐ Bone grafting / socket preservation | ☐ Snoring treatment (after sleep testing) |
| ☐ Complex restorative / full-mouth restoration | ☐ Emergency visit |
| ☐ Other _____ | |

RADIOGRAPHS

- ☐ Sent with patient ☐ Faxed or emailed ☐ Patient will bring ☐ Please take a CBCT / needed images

COMMUNICATION PREFERENCES

- | | |
|---|---|
| ☐ Please call to discuss the case | ☐ Return to referring office for final restoration |
| ☐ Please call after the evaluation | ☐ Dr. Patel to manage both the implant/surgical and restorative phases |

Referring dentist signature _____ Date _____

Fax the completed form to (630) 766-1164 or call (630) 766-0115. Thank you for the referral.