Studio G
Aesthetic & Family Dentistry
"Where art, science and technology meet."

Alexandra Yarborough DDS FACP
Prosthodontist

Referral to Prosthodontist

Full Patient Name: _____ Date: _____

Phone Number: _____ Email: _____

Referring Doctor Name: _____ Phone: _____

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

Appointment type: (*please circle one)* Consultation Treatment

Reason for referral: *(Please mark all that apply)*

- ○ Crowns and/or bridges, tooth/teeth number(s): _____
- ○ Cosmetic consultation & treatment
- ○ Occlusal analysis and/or occlusal equilibration
- ○ Implant planning and restoration- please note areas/tooth numbers: _____
- ○ Full mouth rehabilitation
- ○ Immediate dentures, complete or partial dentures
- ○ Localized treatment of: _____
- ○ Comments or special concerns: _____

_____

_____

Recent full mouth radiographs: ☐ Will accompany patient ☐ Emailed ☐ No current radiographs

Digital radiographs can be emailed to **info@studiogdentist.com**

- ○ Patient to have periodic maintenance/examinations at our office
- ○ Patient to have periodic maintenance/examinations at Studio G Dentistry
- ○ Patient to alternate periodic maintenance/examination visits.

- ○ Email report to referring doctor at: _____

Appointment Status: ☐ Patient will call for appointment
☐ Studio G Dentistry will call patient to coordinate appointment (Preferred)

Please email this form to our office at info@studiogdentist.com or fax it to 919-942-8351 and your patient will be contacted and scheduled for an evaluation.

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