Dr. Leo Malin
Dr. Rachel Malin

Referral for Implant Consultation and Treatment

Date: ______________________________

Patient Information:

Name: ______________________________ **PHONE:** ________________ **DOB:** ____________

Referred For:

- ☐ Single tooth replacement - tooth number(s): ______________
- ☐ Multi-tooth replacement - tooth number(s): ______________
- ☐ Full Arch Implant Restoration: ______________________
- ☐ Bone Grafting
- ☐ Extractions/Third Molar Extractions - tooth number(s): ____________
- ☐ CBCT only
- ☐ Full Mouth Rehabilitation
- ☐ TMD
- ☐ Other: ____________

Additional Comments or Notes.:

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Radiographs Included? ☐ Panorex ☐ Periapicals ☐ CBCT

Refered by:

Office Name: __________________________ **Phone:** ______________________________

Doctor: ______________________________ **Email:** ______________________________

- ☐ Please refer back to my office for the completion of the final prosthetic(s) on the Implants(s)
- ☐ Please complete the final prosthetic(s) on the implant(s)
- ☐ Please call about this case following the consultation

305 3rd Street South
La Crosse, WI 54601

608.498.4660

frontdesk@grdlacrosse.com
www.grandriverdental.com