Patient Information

Name: ________________________
Phone: ________________________
E-mail: ________________________

Treatment Plan

☐ Cosmetic Consultation:

☐ Implant Placement (Teeth Numbers):

☐ All-On-Four:   ☐ Upper Arch   ☐ Lower Arch
                 ☐ Both Arches

Restoration Preference for Implant Treatment

☐ Return the patient after osseointegration

☐ Return the patient with the permanent restoration
   (fabrication of the permanent restoration is included)

☐ Finish to the permanent restoration

Referring Doctor Information

Name: ________________________
Phone: ________________________
E-mail: ________________________

Remarks:

Please fax this form to 615-373-4864