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alberto j. ambard, dds, ms

MAXILLOFACIAL PROSTHODONTICS

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Date of Referral: _____

Referred By: _____ Phone# _____

Patient has been seen in my practice for _____ years

Patient is new to my practice_____

NPI# _____ if referral is related to medical issues, please provide National Provider Identification number for medical billing purposes.

Patient Information:

Name: _____

Address:_____

Phone#: _____

Home Cell Work

ICD-9 Code _____ Diagnosis code is required if related to medical issues

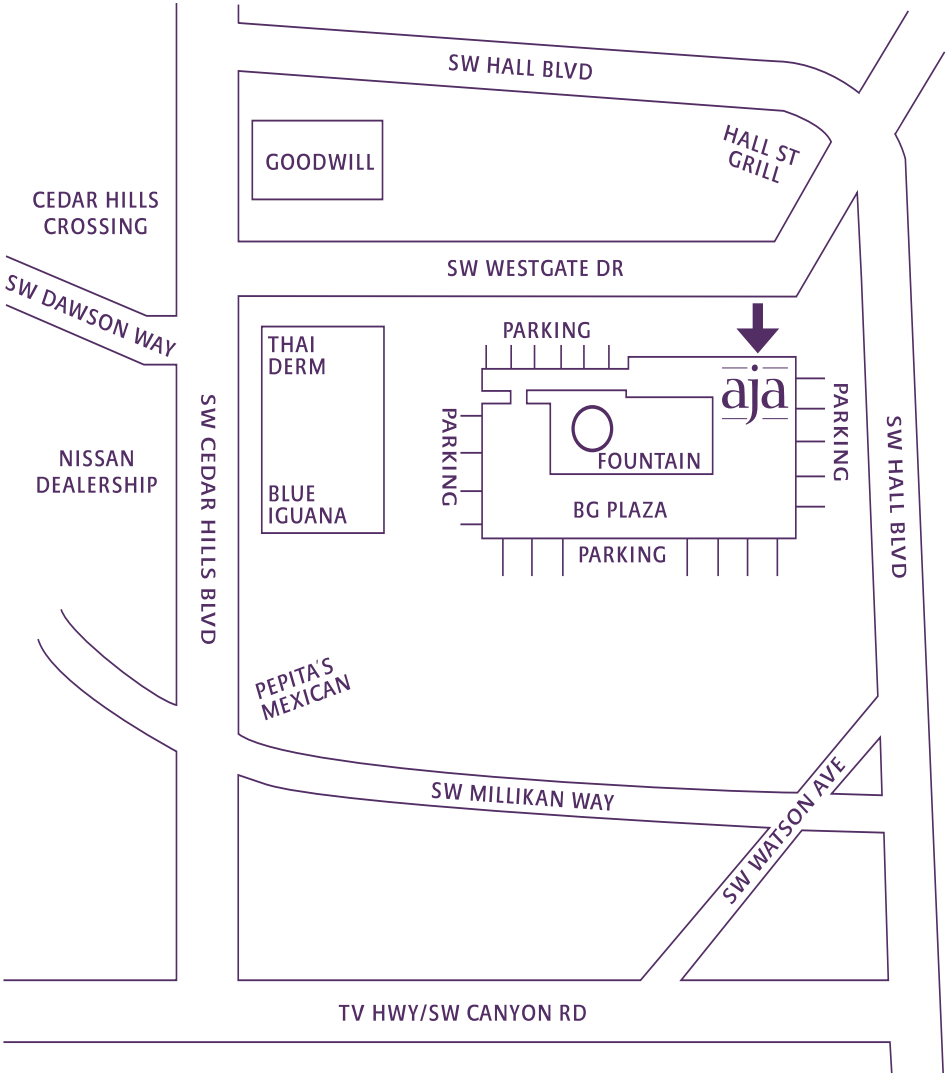
For: _____ MAXILLOFACIAL PROSTHETICS _____ IMPLANTS

_____ COMPLETE/PARTIAL DENTURES _____ TMD/TMJ

_____ SNORING _____ SLEEP APNEA APPLIANCE _____ OBTURATOR

_____ VENEERS, ESTHETIC TREATMENT _____ COMPLEX REHABILITATION

Please include or e-mail current X-rays (PANO, PA's, and FM), Perio charting, CT scan, MRI if available



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