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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 Insurances billing purposes.

Patient Information:

Name: _____

Address: _____

Phone#:_____ ICD-9 Code _____

☐ Home ☐ Cell ☐ Work Diagnosis code is required if related to medical issues

For: _____ IMPLANTS _____ COMPLEX REHABILITATION

_____ TMD/TMJ _____ COMPLETE/PARTIAL DENTURES

_____ SNORING _____SLEEP APNEA APPLIANCE _____ OBTURATOR

_____ MAXILLOFACIAL PROSTHETICS _____ VENEERS, ESTHETIC TREATMENT

Comments: _____

_____

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

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