



Patient information

First and Last Name: _____

Telephone: _____

Referring Doctor Information

Referred By: _____

Telephone: _____

Email: _____

Referring To:

- Dr. Thomas M. Dresen Dr. Lynda K. Bangtson First Available

Referring For: (Please specify below)

- Consultation Only Consultation & Treatment

Implant Treatment:

- Maxillary
 Mandibular

Cosmetic Treatment:

- Crowns/Veneers
 Bridges

Removable Prosthodontics:

- Complete Dentures
 Partial Dentures

Fixed Prosthodontics:

- Maxillary
 Mandibular

TMD/Facial Pain

Snore Guard/TMJ Splints

Other

C/C Remarks: _____

Please Send Applicable X-rays if Available

- X-Rays Available <mailto:info@dresdentistry.com>
- No X-rays Available

Thank You For Your Referral!