



LONGMONT
RESTORATIVE DENTISTRY

TAYLOR GOGGINS DDS, BRIAN C. AGUIRRE DDS, MS
RALF POINEAL DDS
- PROSTHODONTISTS -

Patient's Name: _____ Phone: _____

Referring Doctor's Name: _____

Referring Office Phone: _____ Fax: _____

Referring Office Email: _____

REASON FOR REFERRAL

- Maxillofacial Prosthetics
- Dentures/Partials
- Consultation
- Dental Implants
- Treatment as needed
- Other _____
- Dental Reconstruction
- TMD/Occlusion
- Complex Restorative Needs
- Sleep Apnea
- Implant Complication

Remarks: _____

			a	b	c	d	e		f	g	h	i	j				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R	-----								-----								L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
				t	s	r	q	p	o	n	m	l	k				

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www.LongmontRestorativeDentistry.com
Email radiographs to smiles.lrd@gmail.com



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