

Prosthodontics Referral Form



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Practice Limited to Prosthodontics

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office: (919) 858-8193
fax: (919) 585-8198

Patient Information

Introducing: _____

Date: _____ Phone: _____

DOB: _____ Pre-Med Pt: Yes No

Address: _____

Prosthodontic Treatment Needs

Tooth or Area of Concern: _____

- Implants
- Denture
- Partial
- Wear - Vertical Dimension Problems
- TMD
- Esthetics
- Crown & Bridge
- Other: _____

Comments or Concerns: _____

Referred by Dr. _____

Phone: _____ Fax: _____

Appointment Date: _____ Time: _____

Radiographs: Being Mailed Given to Patient

Emailed to admin@carypros.com Needed

Please fax completed form to: (919) 585-8198
Or email to: admin@carypros.com