**Brandon Kofford, DMD, MS, FACP** **Kevin Lim, DMD, MS, FACP**

*Practice Limited to Prosthodontics*

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www.caryprosthodontics.com email: admin@carypros.com

Date: ______________________________

This will introduce ______________________________

DOB ____________________ Pre-Med Patient: Yes ❑ No ❑

Referred by Dr. ______________________________

Appointment Date: ____________________ Time: ______________

Phone ____________________ (H) ____________________ (Cell)

Prosthodontic Treatment Needs:

Tooth or Area of Concern: ____________________

- ❑ Implants
- ❑ Denture
- ❑ Partial
- ❑ Wear – Vertical Dimension Problems
- ❑ TMD
- ❑ Esthetics
- ❑ Crown & Bridge
- ❑ Other: ______________________________

Other Information:

- ❑ Radiographs available
  (if digital, please email to admin@carypros.com)
- ❑ Radiographs needed
- ❑ Medical concerns ______________________________

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Comments: ______________________________

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