Prosthodontic Specialists
of San Diego

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☐ Miguel A. Grillo DMD

☐ Michael G. Lum DDS

Patient Name ____________________ Date __________

Phone #s H ______________ W ______________

Referring Doctor ______________________________

☐ Patient will call

☐ Please call patient

My appointment

Date __________

Time __________

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Circle Tooth / Area

Recent Full Mouth Radiographs: ☐ Accompany Patient ☐ E Mailed
☐ Patient does not have a current series

How long has the patient been in your practice? ______________________

REFERRED FOR:

☐ Complete Prosthodontic Evaluation
☐ Limited Prosthodontic Consultation
☐ Crown and Bridge
☐ Implant Reconstruction
☐ Aesthetic Dentistry
☐ Complete Dentures
☐ Removable Partial Dentures
☐ Preradiation Evaluation
☐ Maxillofacial Prosthetics
☐ Sleep Apnea / Snoring Appliance
☐ TMD / TMJ Evaluation

Comments: ____

INSTRUCTIONS FOR PATIENTS

Please call for an appointment
If you are taking medications, please bring a list of them with you
Minors must be accompanied by a parent or guardian
Fees are payable at the time of service

☐ E Mail Report to Referring Doctor at: ______________________

ACP American College of Prosthodontists
Specialist Member

WHITE - Give to Patient
YELLOW - Keep in YOUR Patient Chart

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