EZ Dental Clinic

Patient Name: _____Date: _____

Birth date: _____ Phone (Primary): _____

Email: _____ Phone (Other): _____

Address: _____

_____

Referring Office: _____

Referring Doctor: _____

Contact phone: _____

Reason for Referral:

- ☐ Fixed Prosthodontics
- ☐ Implant Prosthodontics
- ☐ Removable Prosthodontics
- ☐ Maxillofacial Rehabilitation

Radiographs:

- ☐ Needed
- ☐ Enclosed

Additional History and Information:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your Referral!

Phone: (425) 746-6090
Fax: (425) 747-9856
Website: ezdentalbellevue.com
Address: 1130 140th Ave. NE #100b Bellevue, WA 98005