Specialty Implant Case Referral

Charles A. Mastrovich, D.D.S.

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Dedicated Implant Mechanical Rescue (IMR) Phone Line: 760-703-0550 Fax 760-746-2008

Patient's Name___________________________ Patient's cell phone number ____________________

Patient's Email Address ____________________ Referral Date __________________ Pre-med ❐Yes ❐No

Referring Doctor's Information:

Name ___________________________________

Office Contact/Rep ________________________

Phone Number ___________________________

Email Address ____________________________

Restorative/Surgeon Information:

Name ____

Phone Number ____________________________________

Email Address _____________________________________

Who is responsible for our fees: ❐Dentist ❐Patient

Implant Information:

Implant Location (tooth replaced): #_________

Implant Size and Type _____________________

Abutment Type and Lab Who Processed _____

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Abutment Mfg. Size and Type ______________________

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Original *Implant* Placement Date ___________________

Original *Restorative* Placement Date ________________

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Are there any loose parts that have come out? If so, Dr. Mastrovich will need to physically examine them before the appointment. ❐The loose parts will be mailed to our office OR ❐The patient will deliver the loose parts.

If the referring doctor wants a healing abutment placed after the procedure, please indicate how it will be delivered to our office: ❐The office will be mailing it to us OR ❐ It will be hand carried by the patient.

Please include a brief synopsis of the situation and what efforts were made and by whom to resolve this case.
(The number of attempts and instrumentation, if any, to resolve this case).

I greatly appreciate the confidence and support you express when you entrust your patients to my care. Please call at anytime if you have questions or concerns. Please email an x-ray for this case to: info@mastrovichdental.com. Your contact at our office is Valerie at 760-703-0550.

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