Specialty Implant Case Referral

Charles A. Mastrovich, D.D.S.

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Dedicated Implant Mechanical Rescue (IMR) Phone Line: 760-741-6650 Fax 760-746-2008

Patient's Name_____ Patient's cell phone number _____

Patient's Email Address _____ Referral Date _____

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 _____

_____

Abutment Mfg. Size and Type _____

_____

Original *Implant* Placement Date _____

Original *Restorative* Placement Date _____

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 760-741-6650.

Charles A. Mastrovich D.D.S.