Joseph A. Lucero, D.D.S.

Prosthodontist

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PATIENT REFERRAL / CONSULT

Patient Name _____ DOB _____

Phone Hm: _____ Wk: _____ Cell: _____

Appt. Date / Time _____ / _____

Radiographic films attached? YES NO

If no films, make as necessary? _____

Referral / Consult for: _____

Evaluation and Treatment ☐ Consultation only - No Treatment ☐

Reason for referral: _____

_____

_____

_____

Other Comments: _____

_____

_____

Referring Doctor _____ Date _____

Referring Doctor Phone # _____