YourDesiredSmile.com

Dr. Luis A. Alicea DMD, MSD - Prosthodontist

Fax Referral Form to : 813-639-0300
Email to: info@yourdesiredsmile.com

Patient Information

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email : _____

Referred By

Referring Doctor (Print): _____

Email : _____

Office Phone: _____ Fax: _____

Patient's Chief Complaint: _____

_____

_____

TMJ (check all that apply)

_____ Jaw Pain
_____ Otalgia
_____ Neck and shoulder pain
_____ Ear stuffiness
_____ Clicking, popping, locking
_____ Limited ability to open and close
_____ Craniofacial Pain
_____ Other: _____
_____ Facial Pain
_____ Tinnitus
_____ Dizziness

Sleep Apnea/Snoring (check all that apply)

_____ Fatigue
_____ Daytime drowsiness
_____ Declined CPAP
_____ Difficulty falling asleep
_____ Wakes up gasping
_____ Other: _____
_____ Snoring
_____ CPAP intolerant

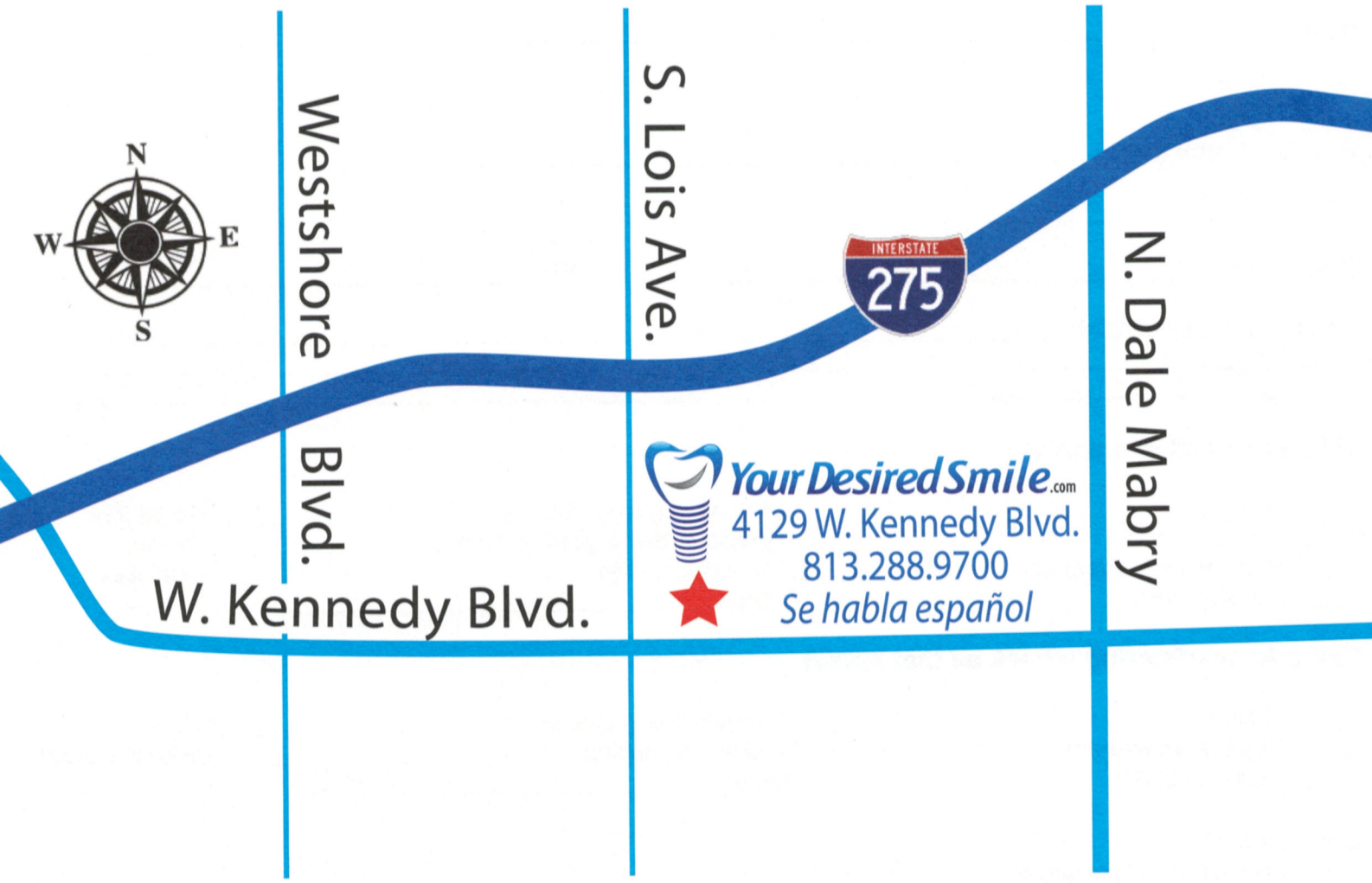
Consult for:

_____ Dental Implants to site # _____
_____ Bone Graft to site # _____
_____ Dentures _____
_____ Extraction of tooth # _____
_____ Complete Oral Rehabilitation _____
_____ Cosmetic Restoration _____
_____ Sedation Dentistry _____
_____ Others _____

Cone Beam CT

_____ Please get 3D tomography only, no consult
_____ Consult with recommended 3D tomography

Thank you for your referral!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