LIFE dentistry

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Dr. Brett Shkopich

Patients name: _____

Phone number: _____

Email: _____

Referall Date: _____

Area of concern

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ Urgent ☐ Routine ☐ Same day tx

☐ Implant (single)
☐ Implant (multiple)
☐ Implant (locator)
☐ Implant (full arch)
☐ CBCT Scan
☐ IV Sedation
☐ Restorative
☐ Endodontic
☐ Extractions
☐ Grafting

Implant Preference:
Nobel Biocare: ☐
Straumann: ☐

Final Restoration:
Your Office: ☐
Our Office: ☐

Other/comments:

Referred by: _____

Phone number: _____

Email: _____

Records sent: Yes: ☐ No: ☐

*Services provided by general dentists