

Dr. Faheem Qazi

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Patient Information

Introducing: _____

Patient's Phone: _____

Date: _____ DOB: _____

Referring Doctor: _____

Referring Doctor's Phone: _____

Reason for Referral

- | | | |
|---|---|--|
| <input type="checkbox"/> Comprehensive Exam | <input type="checkbox"/> Replacement of Missing Teeth | <input type="checkbox"/> Root Canals |
| <input type="checkbox"/> Periodontal Exam | <input type="checkbox"/> Extractions | <input type="checkbox"/> Cosmetic Evaluation |
| <input type="checkbox"/> Emergency Exam | <input type="checkbox"/> Implants | <input type="checkbox"/> Teeth Alignment |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Tooth Pain, Abscess |

Please Mark Teeth or Area to be Treated

	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	
			A	B	C	D	E			F	G	H	I	J				
Right	_____																Left	
			T	S	R	Q	P			O	N	M	L	K				
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	

Radiographs

- Emailed Given to Patient Mailed Please Take

Comments

DENTALARTS

We accept most major PPO insurances and MediCal!