ROGUE VALLEY IMPLANT CENTER™

Date:_____ Patient Name:_____

Patient DOB:_____ Patient Phone #:_____

Referring Office Name:_____

Referring Office #:_____Referring Doctor:_____

Referring Office Email:_____

Evaluate patient for:

- ☐ Extractions
- ☐ Bone Grafting / Ridge Augmentation
- ☐ Dental Implants (surgical phase only by RVIC)
- ☐ Dental Implants (surgical **and** restorative phases both by RVIC)
- ☐ CBCT Only. (area of interest) _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

What is the final restorative treatment plan?_____

Comments:

Instructions:

Please fax this form to RVIC at (541) 292-5869

If you have any questions, please give us a call. (541) 292-5850