



PROSTHODONTICS  
of  
CENTRAL INDIANA

SAVI ABEY, DDS, MSD • KAMOLPHOB PHASUK, DDS, MS, FACP

TELEPHONE: (317) 574-0866 FAX: (317) 574-0867

Email: info@teethin.com

Referring Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Please examine patient for:

- Complete Dentures
- Implant Therapy Teeth # \_\_\_\_\_
- Limited Treatment: Upper \_\_\_\_\_ Lower \_\_\_\_\_ Tooth # \_\_\_\_\_
- Comprehensive Prosthodontic Treatment
- Diagnosis and Treatment Plan only (Referring dentist to treat)

Notes to prosthodontist: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Radiographs enclosed:  Yes  No

**Patient Hygiene Schedule:**

- Hygiene recare appointments in Referring Doctor's office exclusively
- Alternating recare appointments between Referring Doctor and Prosthodontist  
Every  3 months  6 months  Other
- Recare appointments in Prosthodontist's office (upon request only)

Appointment Date & Time: \_\_\_\_\_

PLEASE FAX OR EMAIL TO PROSTHODONTICS OF CENTRAL INDIANA



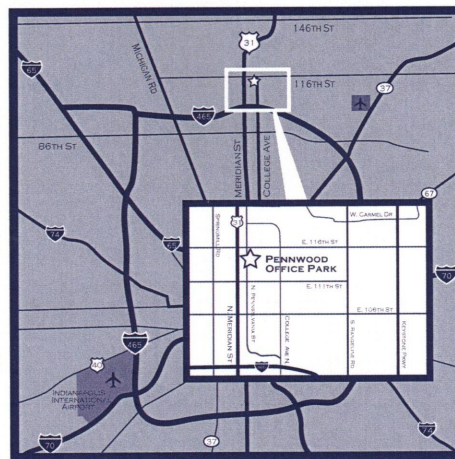
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Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

TEAR AT PERFORATION AND GIVE TO PATIENT



Notes: \_\_\_\_\_  
\_\_\_\_\_

**Penwood Office Park**

11405 North Pennsylvania St, Suite 110, Carmel, IN 46032

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[www.prosthodonticsin.com](http://www.prosthodonticsin.com)