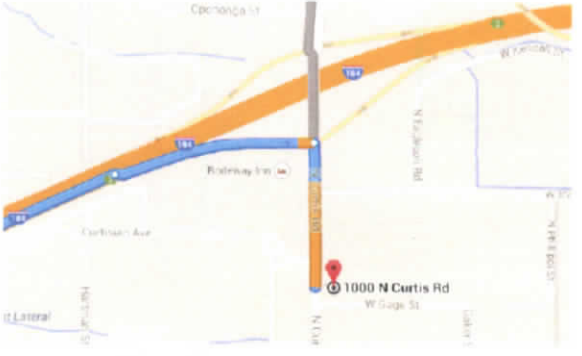
BOISE PROSTHODONTICS

208-376-0567
Michael Gurney DDS, MS
Christopher Jones, DMD, MS, FACP

Patient's Name: _____ **Patient's Phone:** _____ **Patient's Date of Birth:** _____

Patient's Address: _____
_____

Reason for Referral: (Short description of situation and what has been discussed with the patient)



Request by Referring Doctor Regarding Involvement and Follow Up: (How much do *you want to be involved in treatment?*)

Referring Doctor Name: _____
Phone: _____
Email: _____
Address: _____
_____

Radiographs Available: Y N
Photographs Available: Y N
Diagnostic Casts Available: Y N
Would like to meet and discuss treatment: Y N
Would like to meet and discuss techniques: Y N
Consultation (second opinion) Y N
Full Evaluation for Treatment Y N

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