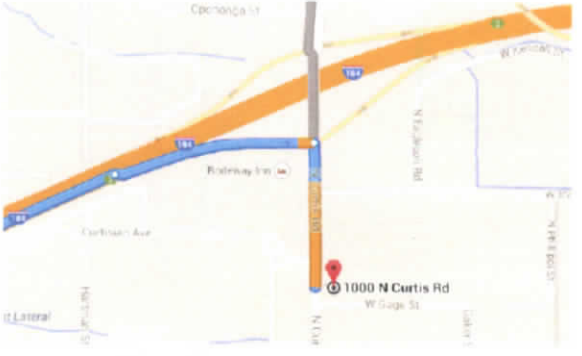
# BOISE PROSTHODONTICS

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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WWW.BOISEPROSTHODONTICS.COM
WWW.IDAHOIMPLANT.COM
OFFICE@BOISEPROSTHODONTICS.COM
P: 208-376-0567
F: 208-376-0661
1000 N CURTIS RD, SUITE 203, BOISE, ID 83706

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