_____ James D. Allen, DDS, FACP
_____ George H. Clayton, DDS, FACP
_____ Bryan McLaughlin, DMD, FACP
_____ First Available

1177 Old Hickory Blvd.; Suite 102
Brentwood, TN 37027-4242
Phone: 615-690-5400
Fax: 615-690-5404
www.tennesseedentalcare.com

PROSTHODONTIC EVALUATION/TREATMENT

Patient Name: ______________________ **Date:** __________

Patient Phone: ______________________________________

Referred by: ____

Doctor's Phone: ______________________________________

Office Email: ____

Please indicate the type of evaluation and area needed:

_____ Fixed Prosthodontics
_____ Removable Prosthodontics
_____ Implant Prosthesis
_____ Maxillofacial Prosthesis
_____Esthetic Evaluation and Treatment
_____ Other ____

Reason for Visit: ____________________________________

____

____

X-Rays: **Needed** **Emailed** **Given to Patient**

IMPORTANT PATIENT INFORMATION

Appointment Date: __________ **Appointment Time:** ________

- A parent or guardian must accompany patients under 18 at the time of the initial consultation.
- Please bring this referral slip, a list of all medications, and your dental insurance cards.

Middle Tennessee Prosthodontics

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1177 Old Hickory Blvd
(Look for the
American Flag)