smile solution
DENTAL IMPLANT CENTER

WILLIAM SCRUGGS, DDS, MS
Prosthodontist

ANTHONY GRAGG, DMD, MS
Prosthodontist

## Complimentary New Patient Consultation and CT Scan

PATIENT NAME: _____

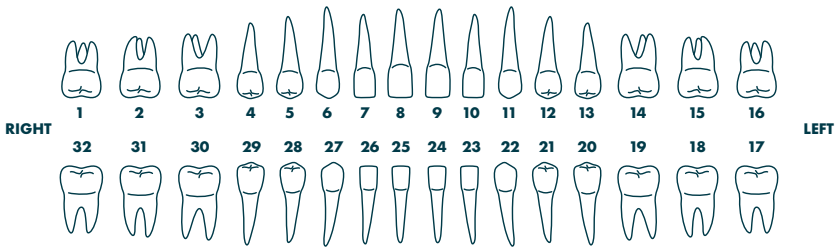
PATIENT PHONE: _____ PATIENT DOB: _____

PATIENT EMAIL: _____

**RADIOGRAPHS:** ☐ PLEASE TAKE ☐ EMAILED (LAST TAKEN) _____
*referrals@smilesolution.com*

**REASON FOR REQUEST:**

- ☐ UPPER FULL ARCH IMPLANT BRIDGE
- ☐ LOWER FULL ARCH IMPLANT BRIDGE
- ☐ IMMEDIATE COMPLETE DENTURE
- ☐ IMMEDIATE OVERDENTURE
- ☐ COMPLETE DENTURE
- ☐ OVERDENTURE
- ☐ SINGLE TOOTH IMPLANT(S)
- ☐ IMPLANT BRIDGE(S)




REFERRING DOCTOR: _____

DOCTOR'S PHONE: _____ DATE: _____

NOTES: _____

_____

_____

927 N BRIGHTLEAF BLVD.
SMITHFIELD, NC 27577
Tel: 919-205-1938
referrals@smilesolution.com

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**Information for First Visit:**

- Please bring all x-rays, this referral slip, pertinent medical information and a list of ALL medications you are currently taking.
- Please bring your government issued photo ID.
- A parent/legal guardian must accompany any patient under 18 years at the time of the consultation and following surgery.
- If a power of attorney has been appointed, they must attend the initial appointment and bring all related paperwork.

**Please call our office if you have any questions: 919-205-1938**

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