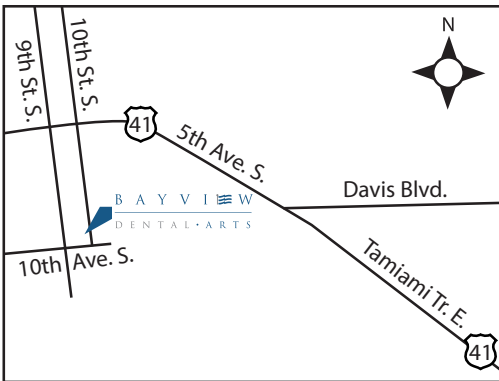


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B A Y V I W

D E N T A L • A R T S

Introducing: _____

Phone Number: _____

Date of Birth: _____

Referred By: _____

Phone Number: _____

Email: _____

.....
Please circle specific area(s) of concern:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

.....
Treatment Consideration

- | | | | |
|--|--|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Consultation/Exam | <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Extractions | |
| <input type="checkbox"/> Full Mouth Rehabilitation | <input type="checkbox"/> Crown/Bridge | <input type="checkbox"/> Removable | |
| <input type="checkbox"/> Restorative | <input type="checkbox"/> Pathology | <input type="checkbox"/> Grafting | <input type="checkbox"/> Other |

.....
Endodontic Consideration

- | | |
|--|--|
| <input type="checkbox"/> Consultation and diagnosis only | <input type="checkbox"/> Consider surgical endodontics |
| <input type="checkbox"/> Consultation and treatment if indicated | <input type="checkbox"/> Prepare post space |
| <input type="checkbox"/> Retreatment of previous Root Canal | <input type="checkbox"/> Place pulp chamber buildup |
| | <input type="checkbox"/> Other |

.....
Comments _____

.....

Radiographs/Records:

- | | | | |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Enclosed | <input type="checkbox"/> E-mailed | <input type="checkbox"/> Mailed | <input type="checkbox"/> Clinical Notes |
| <input type="checkbox"/> Patient Will Bring | <input type="checkbox"/> CBCT | <input type="checkbox"/> None Provided | <input type="checkbox"/> Reports |

.....
Referred To: _____

Address: _____

Phone: _____

E-mail: _____

Appointment Date: _____ Time: _____

Edward A. Scherder DMD, JD • Robert Hedgepath DMD • Patrick Carrigan DMD
Kurtis Hussey DMD • Jose Horak DMD • Katie Rodriguez DMD, MS