Kevin C. Lin, DDS
BOARD CERTIFIED PROSTHODONTIST
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PATIENT FULL NAME: _____
PATIENT PHONE: (_____)_____
EMAIL: _____

REFERRED BY: DR. _____
OFFICE PHONE: (_____)_____
OFFICE ADDRESS: _____
EMAIL: _____

REASON(S) FOR REFERRAL:

☐ Complex Treatment Planning ☐ Implant Prosthesis ☐ High Esthetic Expectation
☐ Dentures or Partials ☐ Full Mouth Rehabilitation ☐ Problem-Focused Treatment: _____

COMMENTS / SPECIAL CONCERNS:

_____
_____

X-RAY, PHOTOS, AND/OR ADDITIONAL DOCUMENTS:

☐ Sent by E-mail ☐ Sent with Patient
☐ To Be Taken

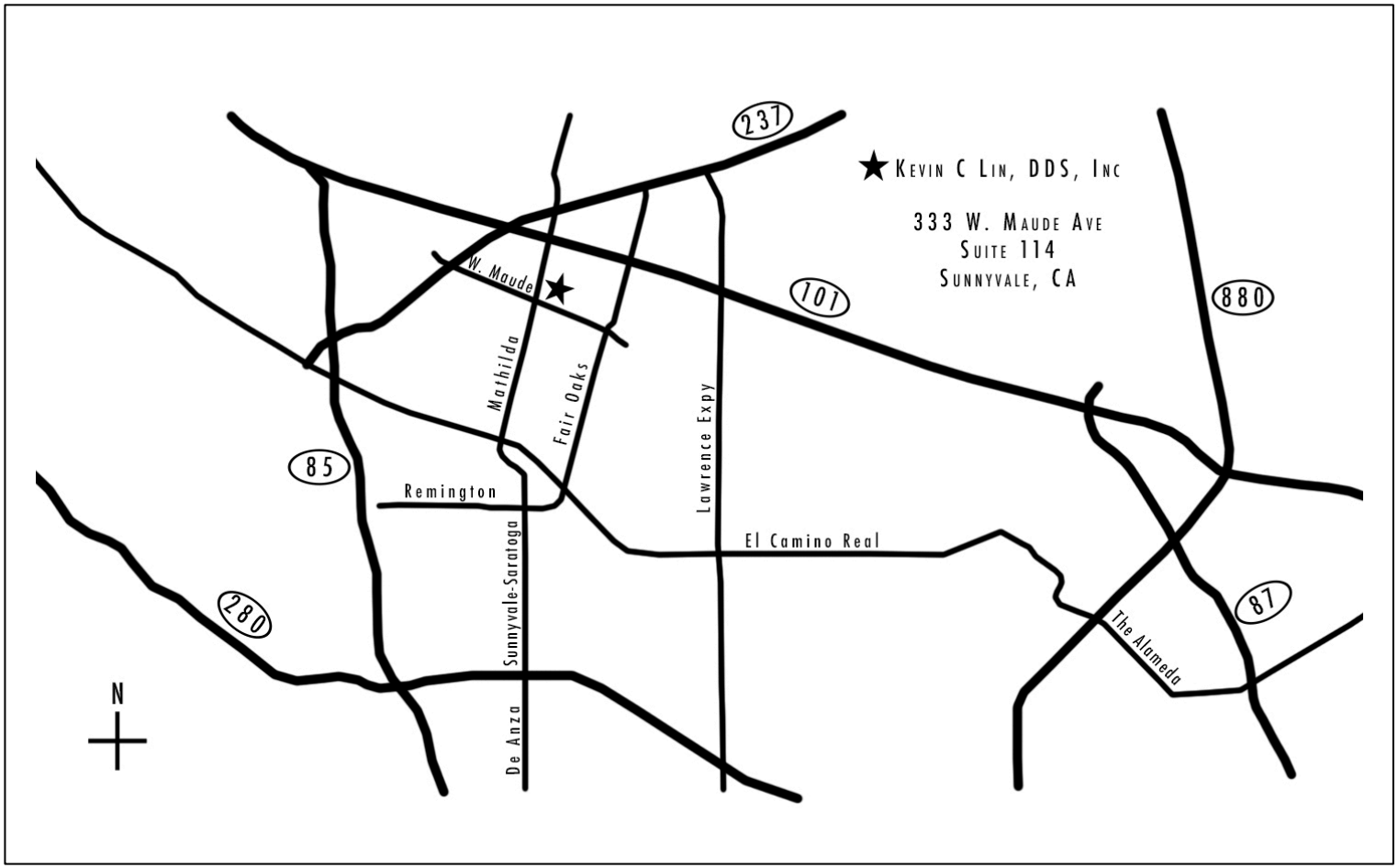
PREFERRED METHOD(S) OF COMMUNICATION WITH REFERRING DOCTOR:

☐ Phone Discussion ☐ Written Report by Email ☐ Written Report by Mail

◆ ◆ ◆

PLEASE FAX THE COMPLETED FORM TO 408.686.2033 OR EMAIL US AT **KEVIN.LIN.DDS.INC@GMAIL.COM**

THANK YOU FOR YOUR INTEREST IN INVOLVING US IN YOUR PATIENT SERVICE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280
87
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