

Date: _____

Patient Name:

Phone Number:

Referred by: _____

Reason for Referral (please include what has been discussed with the patient, patient's expectations and concerns, and if the patient is aware of the significance of their problem):

Please email radiographs to: **patient@vtprosthodontics.com**

Drs. Merrick and Gragg request the most current FMX, pan and any specific PAs