Gerard Cuomo

Microscope Enhanced Dentistry

Doctor, thank you, in advance, for your referral. Please complete and sign this referral form and have it faxed (561-391-6299) or emailed (mailbox@gcuomodds.com) to my office. E-mail any x-rays or photos per the instructions below. After Dr. Cuomo reviews this referral form and the x-ray(s), your patient will be called to schedule an appointment. Following treatment, your patient will be referred back to your office and a report will be sent to you. If you have any questions or concerns or would like to discuss your referral, please do not hesitate to call.

Patient Information: _____
Last Name First Name

_____
Home # Cell #

_____ Does he/she pre-medicate? [ ] Yes [ ] No
Email address

Were any prior rescue attempt(s) made by you or another dentist? [ ] Yes [ ] No

Referring Dentist: _____

_____
Office # Email address

NOTE: Rescue fees will be presented to your patient at his/her appointment. There is a risk in retrieving broken implant parts and more extensive treatment may be needed if the implant rescue is unsuccessful, including removal of the existing implant fixture and replacement with a new implant fixture.

Implant Surgeon: _____

_____
Office # Email address

Implant Information: Implant Location: _____ Date Placed: _____

Implant Size and Brand: _____

Restorative Dentist: _____

_____
Office # Email address

Date Implant Crown/Bridge was placed: _____

X-rays: **Email x-ray(s)and any photos to mailbox@gcuomodds.com and dr@gcuomodds.com**

Parts/Prosthesis: What parts, if any, will you be sending with the patient? _____
The prosthesis: [ ] remains in the mouth [ ] is out of the mouth (patient should bring to appt.)

Payment for services: [ ] Patient is responsible for payment. [ ] Dentist is responsible for payment.

Reason for Referral/Other Information: _____

_____

_____

Dr. Signature: _____ Date: _____

900 NW 13th Street, Suite 301 | Boca Raton, FL 33486 | Telephone (561) 391-6290 | Fax (561) 391-6299 | www.gcuomodds.com