Treatment / Consultation Request

ESTETICA
COSMETIC & RECONSTRUCTIVE SURGERY OF SCOTTSDALE

Corwin D. Martin, M.D., D.D.S.
9450 E Ironwood Square Drive
Scottsdale, AZ 85258

voice: (480) 551-0581
fax: (480) 551-0585

referrals@anewbeautifulyou.com

Patient: _____

Date: _____

Phone Number: _____

Referring Doctor: _____

This Patient requires the following:

☐ **Extraction of #:** _____

_____

☐ **Discuss Dental Implants if Indicated**

☐ **Dental Implant Placement #:** _____

☐ **Alveoplasty:** **UL** **UR** **LL** **LR**

☐ **Sinus Lift:** **Right** **Left**

☐ **Ridge Augmentation (Location):** _____

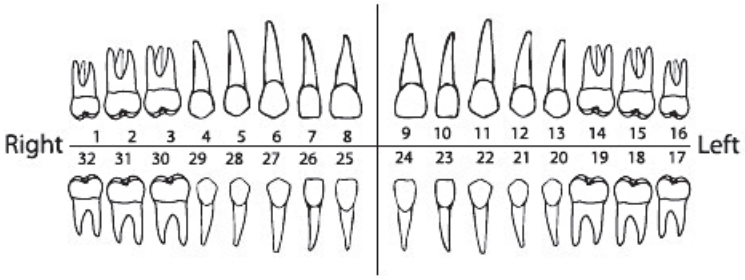
☐ **Biopsy (location):** _____

_____

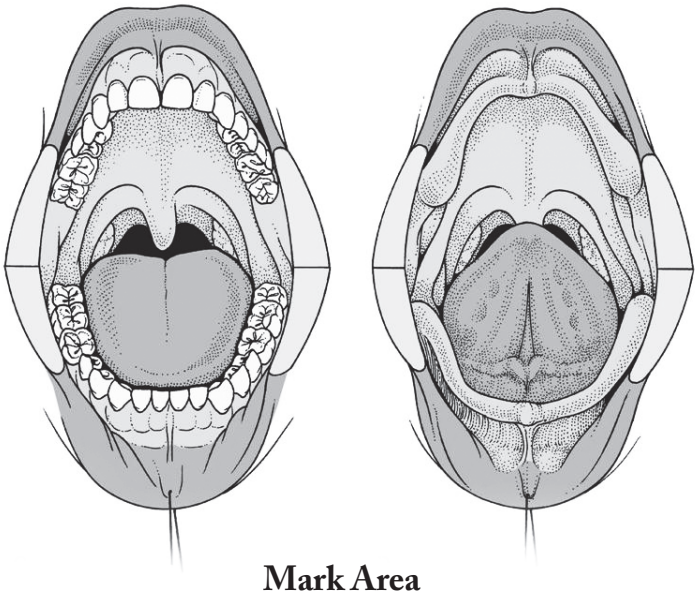
Remarks: _____

_____

_____



Circle Teeth



Mark Area

Fax to: 480-551-0585

White Copy: Send with patient | Yellow Copy: For your records

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