Laying the foundation to healthy smiles

Dr. Sonia Leziy
Dr. Brahm Miller
Dr. Mathieu Nault
Dr. Iain Hart

REFERRING DENTIST NAME:	REFERRAL DATE: M / D / Y
REFERRING OFFICE:	PHONE:
PATIENT NAME:	DOB: M / D / Y
PHONE:	
EMAIL:	

PERIODONTICS: **Dr. Sonia Leziy** **Dr. Mathieu Nault** **Dr. Iain Hart**
☐ IMPLANT CONSULT: SITES TO BE TREATED
☐ IMPLANT DISEASE/COMPLICATIONS: SITES TO BE ASSESSED
☐ COMPREHENSIVE PERIO CONSULTATION
☐ RECESSION: GENERALIZED / LOCALIZED
☐ CROWN LENGTHENING: AREA(S)
☐ PATHOLOGY: AREA(S)
☐ OTHER: EXTRACTIONS, BONE GRAFTS
Please describe condition to be assessed and/or treated:

PROSTHODONTICS: **Dr. Brahm Miller**
☐ COMPREHENSIVE PROSTHODONTIC EXAM
☐ SPECIFIC PROSTHODONTIC EXAM
☐ FIXED / REMOVABLE PROSTHESIS
☐ BOTOX
Please describe condition to be assessed and/or treated:

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