CAROLINA PROSTHODONTIC AND IMPLANT CENTER

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Fax: 336-274-5493

www.CarolinaNewSmile.com

Referred To: ___DR. PHILLIPS ___DR. KEBLAWI ___DR. BRENES ___FIRST AVAILABLE

Referring Doctor: _____ **Email/Phone:** _____

Patient Name: _____ **DOB:**_____

Patient Phone: _____ **Referral Date:** _____

Referral Reason: _____

_____

_____

_____

_____

Available x-rays: _____ **PA's** _____ **PAN** _____**BW** _____ **CBCT**

_____ **PHOTOS** _____ **MODELS** _____**INTRAORAL SCAN**

Additional Info: _____

_____

_____

_____

Please use: **contact@CarolinaNewSmile.com** to email your referral and records. Attach additional information as needed.