Downtown Dentistry

Prosthodontist

Jang C. Chou DDS, MS

711 Navarro Street Suite 101, San Antonio TX, 78205

TEL: (210) 222-8260
FAX: (210) 222-2461

sanantoniodowntowndentistry@gmail.com

Referring Doctor _____

Today's Date _____

Patient Name _____ Birthdate _____

Patient Phone Number (H)_____ (C)_____

Patient Address _____

Referred for Full Prosthodontic Evaluation
with attention to:

- ◻ Complete Denture(s)
- ◻ Veneers / Fixed Reconstruction
- ◻ Removable Partial Denture(s)
- ◻ Implant Supported Removable
- ◻ Implant Supported Fixed
- ◻ Other _____

Radiographs

- ◻ Enclosed
- ◻ Emailed
- ◻ Patient will bring
- ◻ Please take

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Comments: _____

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- ◻ Patient will call
- ◻ Please call patient