STUART RIMES, DDS, MS
PROSTHODONTICS
IMPLANTS, ESTHETICS, RECONSTRUCTIVE
DENTISTRY

OFFICE: 281.313.1565/FAX:281.313.1575
SUGAR LAND TOWN SQUARE
15958 CITY WALK SUITE 230 SUGAR LAND TX, 77479
EMAIL: DR.RIMES@COMCAST.NET

Patient Name:______________________________ Phone number: ________________________

Please evaluate this patient for the following prosthodontic treatment(s):

______ Complete and/or Partial Dentures ______ Implant restoration

______ Full Mouth Rehabilitation ______ Localized treatment of _______________

Clinical Information:

____

____

Recent Treatment:

____

____

Radiographs:

____ Will be sent to you ____ Accompany the patient ____ Please take new radiographs

Surgical Treatment:

____ Pending

____ Implant Surgery Scheduled Date:______________

____ Implant Surgery Completed Date:______________

Implants Placed:

Tooth Number(s):____

Type: ____

Size: ____

Prognosis:

____

____

☐ Dr. Rimes, please call referring doctor before patient is seen.

Please fax this form to 281.313.1575 and give form to patient

Referred By:_________________________________ Phone: _________________________