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

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SUGAR LAND TOWN SQUARE
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EMAIL: STUART@RIMESDDS.COM

Referred By:__________________________________**Ph:** ___________________________

This is to introduce: ____

Phone: ______________________________________

For prosthodontic evaluation and treatment:

_______ Complete and/or Partial Dentures
_______ Implant restoration
_______ Full Mouth Rehabilitation
_______ Localized treatment of ____________________________________

Clinical Information: ____

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Recent Treatment: ____

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Radiographs:

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

Surgical Treatment:

____ Pending ____ Implant Surgery Schedule Date ____ Implant Surgery Completed Date

Implants Placed:

Tooth Numer(s):____
Type: ____
Size: ____

Prognosis: ____

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______ **Dr. Rimes please call referring doctor before patient is seen.**

Please fax this form to 281.313.1575 and
Give form to patient