SYDNEY DENTAL
AESTHETICS AND IMPLANTS

PATIENT INFORMATION

SURNAME   MR / MRS / MISS / MS / DR   OTHER NAMES

_____

D.O.B.   SIGNIFICANT MED HX:

_____

HOME ADDRESS   TEL

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REASON FOR REFERRAL

☐ DENTAL IMPLANT AT SITE/S...   ☐ FULL-ARCH IMPLANT RECONSTRUCTION
☐ ONLAY BONE GRAFTING   ☐ EXTRACTION & SOCKET PRESERVATION
☐ SOFT TISSUE SURGERY/GINGIVAL RECESSION   ☐ RIDGE/SITE DEVELOPMENT
☐ EXTRACTION & IMMEDIATE IMPLANTATION   ☐ MANAGEMENT OF COMPLICATION
☐ DENTURE STABILISATION   ☐ ALL-ON-4
☐ SINUS GRAFTING   ☐ SIMPLANT SURGICAL PLANNING
☐ IMPLANT REMOVAL   ☐ IMPLANT AND CROWN PACKAGE
☐ OTHER - PLEASE SPECIFY

FURTHER DETAILS

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ATTACHMENTS: ☐ PHOTOGRAPHS   ☐ OPG   ☐ CT SCANS   ☐ PA'S   ☐ SURGICAL STENT

PREFERRED IMPLANT SYSTEM
☐ STRAUMANN   ☐ ANKYLOS C/X   ☐ ZERAMEX
☐ ASTRATECH EV   ☐ NEODENT   ☐ OTHER
☐ NOBEL BIOCARE   ☐ SOUTHERN IMPLANTS   ☐ LEAVE CHOICE TO IMPLANT SURGEON

NUMBER OF IMPLANTS REQUIRED _____
ADDITION OF PRGF OR GROWTH FACTORS: ☐ YES   ☐ NO
DENTURE STABILISATION: ☐ LOCATORS   ☐ BALLS   ☐ BAR   ☐ DOUBLE CROWNS   ☐ SYNCONE

PROSTHETICS
☐ PLEASE COMPLETE BOTH SURGICAL AND PROSTHETIC PHASES
☐ PLEASE COMPLETE ONLY SURGICAL PHASE AND RETURN PATIENT FOR PROSTHETIC PHASE
☐ I WOULD LIKE THE "SPECIAL IMPLANT AND CROWN PACKAGE"

REFERRING PRACTITIONER

NAME   TEL

_____

EMAIL   SIGNATURE & DATE

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