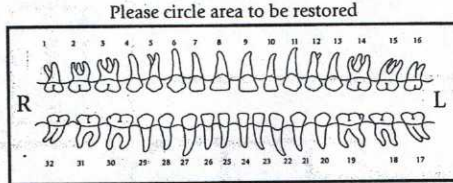




# DENTAL IMPLANT SOLUTIONS

I am referring: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_



Please call:  Before consultation  After consultation  Call not needed

Initial restoration of implants

TX desired \_\_\_\_\_

Implant sites \_\_\_\_\_ Implant system \_\_\_\_\_

Implant sizes \_\_\_\_\_

Replacement of existing prosthesis

Implant system/sizes \_\_\_\_\_

Repair of prosthesis \_\_\_\_\_

Notes \_\_\_\_\_

Patient's general dentist \_\_\_\_\_

27015 169th Pl. SE, Ste 100  
Covington, WA 98042

Phone: 425-224-2452  
Fax: 425-224-2760

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