

# Smile Prosthetics Referral

Phone (406)898-1744 Fax (406)219-2309  
115 W Kagy Blvd Ste E, Bozeman, MT 59715

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Telephone # \_\_\_\_\_

Please treat patient for a partial denture  Maxillary  Mandibular

Please treat patient for an immediate denture  Maxillary  Mandibular

Additional instructions:

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

X : Teeth treatment planned for extraction , O : Teeth staying , — : Teeth missing

\_\_\_\_\_  
Office Name

\_\_\_\_\_  
Signature of Prescribing Doctor