JAMES A. OSHETSKI, DDS

IMPLANT AND RESTORATIVE DENTISTRY
(207) 729-1159

Patient Name _____ Date of Birth _____

Email _____ Phone _____

Referring Dr. and Practice Name

_____

Email _____ Phone _____

Reason for Referral:

- ☐ Single Implant Treatment
- ☐ Implant Complications
- ☐ Full Arch/Full Mouth Implant Rehabilitation
- ☐ Facial Pain Therapy (TMD/J, Appliance, Botox, etc.)
- ☐ If other, please explain:

_____

_____

Please submit relevant radiographs with completed form.
Thank you for your referral!

14 Maine Street, Suite 409, Brunswick, ME 04011

www.droshetski.com (207) 517-6852 info@droshetski.com