Doctor / Dentist Referral Form

SMILE NOVA IMPLANT CENTER · WOODBRIDGE, VA
4335 Ridgewood Center Drive, Woodbridge, VA 22192
(571) 285-2521 · contact@smilenovaimplantcenter.com · smilenovaimplantcenter.com
Hours: Mon–Fri 2–7 PM · Saturday 9 AM–4 PM · Sunday Closed

Referred to: **Smile NOVA Implant Center** · Attn: **Dr. Far Soltanian**

HOW TO SEND THIS REFERRAL

1. Call (571) 285-2521 · **2. Email** this completed form to contact@smilenovaimplantcenter.com · **3. Submit online** (and upload x-rays) at **smilenovaimplantcenter.com/referral**

REFERRING DOCTOR

Name _____ **Practice** _____ **Date** _____

Phone _____ **Email** _____ **Fax** (if any) _____

Address _____

PATIENT

Name _____ **Date of birth** _____ **Phone** _____

Email _____

☐ Patient has Medicaid **Medicaid ID #** (if applicable) _____

REASON FOR REFERRAL

- ☐ Single implant
- ☐ Full-arch / All-on-X style full-mouth restoration
- ☐ Bone grafting / sinus lift
- ☐ Failing implant evaluation
- ☐ Multiple implants
- ☐ Extraction(s) with immediate implant
- ☐ Implant consultation / second opinion
- ☐ Other: _____

Tooth #(s) — Universal numbering (check boxes and/or write numbers below)

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

Tooth #(s) _____

ITEMS ENCLOSED

- ☐ X-rays
- ☐ Intraoral scan
- ☐ CBCT
- ☐ Notes / charting

URGENCY

- ☐ Routine
- ☐ Urgent (patient in discomfort)
- ☐ Soon (within 2 weeks)

COMMENTS / CLINICAL NOTES

Relevant history, medical alerts, or treatment already started:

_____

_____

_____

_____

REFERRING DOCTOR SIGNATURE

Signature _____ **Print name** _____ **Date** _____