

STEVEN SCHMID, D.D.S.

PROSTHODONTIST

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DATE: _____ REFERRING DOCTOR: _____

THIS IS TO INTRODUCE: _____

CELL PHONE: _____ EMAIL: _____

AREAS OF CONCERN (Check All That Apply)

- | | |
|--|--|
| <input type="checkbox"/> Terminal Dentition | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Fixed Prostheses/Hybrids | <input type="checkbox"/> Full Mouth Rehabilitations |
| <input type="checkbox"/> Implant Overdentures | <input type="checkbox"/> Removable Partial Dentures |
| <input type="checkbox"/> Conventional Dentures | <input type="checkbox"/> Other |

Comments: _____

☐ **PATIENT WISHES TO MAINTAIN WITH REFERRING DENTIST**

☐ **COMPLETE TRANSFER OF CARE**