



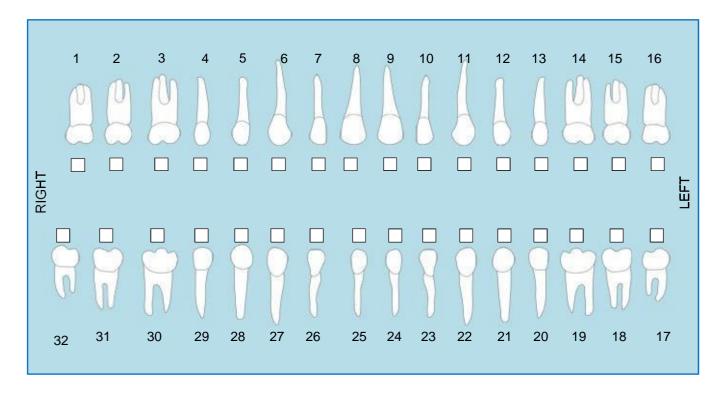
800 Juan Tabo Blvd NE, Ste Q, Albuquerque, NM $\,$

Phone: 505 554 2262 Fax: 505 554 2697 Email: drdentalnm@gmail.com

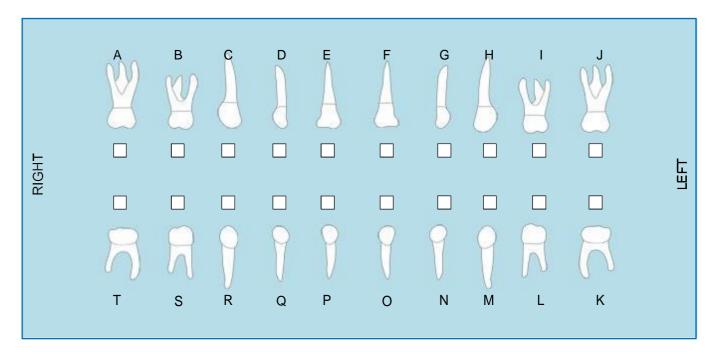
PATIENT REFERRAL FORM

REFERRING TO DOCTOR —					
	☐ DR. KRANTI BELLAM	DMD, MDS		☐ DR. SUNEEL NAMBURI	DMD, MDS, MFD
		PATIENT INI	FORMATION	I 	
Last Name:First Name:					
	Telephone:				
	Patient will call for Dental Appointment*		○Yes	○ No	
	Please call patient to schedule a Dental Appointment*		○Yes	○ No	
	If Patient is in pain and nee	ds to be seen as soon as pos Scheduling First a		nform our Patient Coordinator	· when
		REFERRING DOCT	OR INFORM	ATION	
	Referred By*:	Referred By*:		Referring Date*:	
	Telephone*:		Email:		
Т	Please call me before proce	eeding with treatment* O Yes			
	Comprehensive evaluation Chipped / Broken teeth Dental Caries / decay Emergency Exam / Pain Oral cancer screening Crowns / Bridges Dental hygiene Halitosis / Brad Breath Gum disease / Periodont	Tooth Extract Night Guard / Braces / Orth Frenectomy Sealents Fillings/ Filling Root canal th	Mouth Guard odontics g replacement erapy	Sleep Apnea A Trauma Ulcer / Mouth S Worn-out teeth Missing teeth r -Bridge -Partia -Dentu	Sores neplacement e
	Others:				
	RADIOGRAPHS	MODELS		Special instructions or Rer	narks
	Date taken: Being Mailed Being Emailed Given to Patient No Radiographs Please Take	Being Mailed Given to Patient No Models Please Take			

PERMANENT TEETH EXTRACTIONS



PRIMARY TEETH EXTRACTIONS



Please Verify Teeth for Extraction: