ENVISION™
Implant Continuum

CAROLINAS CENTER FOR ORAL & FACIAL SURGERY
mycenters.com

Upon submission of the completed form, you will be given the opportunity to upload X-rays and print or save a copy of this form for your records.

Patient _____ Date of Birth _____
FIRST NAME LAST NAME

Phone (Home) ( ) _____ (Cell) ( ) _____

Address _____
STREET CITY STATE ZIP

Email _____

Specialists in Dental Implants

To schedule an appointment, please email Envision@mycenters.com or call (704) 295-4654.

☐ **BLAKENEY/BALLANTYNE**
- ☐ Hunter Dawson, DMD, MSD
- ☐ Richard A. Kapitan, DDS, MS, FACS
- ☐ John C. Nale, DMD, MD, FACS

☐ **GASTONIA**
- ☐ John W. Robinson, III, DMD

☐ **LAKE NORMAN/DENVER**
- ☐ Daniel R. Cook, DDS, MD

☐ **ROCK HILL**
- ☐ John H. Wessel, DMD, MD

☐ **UNIVERSITY—CHARLOTTE**
- ☐ Peter B. Franco, DMD, FACS

Treatment Planning

- ❑ I will complete all restorative work and complete the case on my own including preoperative records and conversion in CCOFS office. ❑Conventional ❑Guided
- ❑ I would like to refer the patient to Dr. Dawson and Surgeon to have complex implant rehabilitation completed. *

* This constitutes complete referral and then return of patient for ongoing care.

Referring Doctor _____ Date _____

Phone ( ) _____ Email _____