CAROLINAS CENTER FOR
DENTAL IMPLANT SURGERY

# Implant Referral Form

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

Parents *(if minor)* _____

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

Address _____
STREET CITY STATE ZIP

Email _____

## Implant Specialists

☐ **BILLINGSLEY RD.—CHARLOTTE**
- ☐ Bart C. Farrell, DDS, MD
- ☐ Brian B. Farrell, DDS, MD, FACS
- ☐ Waheed V. Mohamed, DDS, MD

☐ **BLAKENEY/BALLANTYNE**
- ☐ Christoper R. Abernathy, DMD
- ☐ Brian B. Farrell, DDS, MD, FACS
- ☐ Richard A. Kapitan, DDS, MS, FACS
- ☐ John C. Nale, DMD, MD, FACS

☐ **CHERRYDALE/SIMPSONVILLE**
- ☐ Brett Shigley, DMD, MS

☐ **CONCORD**
- ☐ Danielle G. Gill, DMD
- ☐ Nicholas J. Kain, DDS

☐ **GASTONIA**
- ☐ Travis R. Nesbitt, DMD, MPH
- ☐ John W. Robinson, III, DMD

☐ **GREENVILLE**
- ☐ Jim W. Howell, DMD

☐ **LAKE NORMAN/DENVER**
- ☐ Daniel R. Cook, DDS, MD
- ☐ Travis R. Nesbitt, DMD, MPH

☐ **MATTHEWS**
- ☐ J.D. Kisella, DDS, MD

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

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

## Implant Treatment Planning

Patient Assessment _____

_____

Please evaluate for possible:

**Maxillary Prosthesis**
- ☐ Individual (teeth #'s _____ )
- ☐ Bridges (teeth #'s _____ )
- ☐ Full Arch (teeth #'s _____ )
- ☐ Complete Removable Prosthesis (teeth #'s _____ )

**Mandibular Prosthesis**
- ☐ Individual (teeth #'s _____ )
- ☐ Bridges (teeth #'s _____ )
- ☐ Full Arch (teeth #'s _____ )
- ☐ Complete Removable Prosthesis (teeth #'s _____ )

**Please Specify Implant System of Choice:**
- ☐ Astra
- ☐ Nobel Biocare
- ☐ Straumann
- ☐ Zimmer Biomet
- ☐ Zygomatic Implants
- ☐ Other _____

**Please evaluate for possible:**
- ☐ Alveolar Ridge Distraction
- ☐ Bone Graft
- ☐ Sinus Lift
- ☐ Soft Tissue Graft
- ☐ Vestibuloplasty
- ☐ Other _____

Referring Doctor _____ Phone Number _____ Date _____