Shor Dental

www.shordental.com

Alexander Shor DMD, MSD **Kavita Shor BDS, MSD**

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PROSTHODONTICS

Restorative / Esthetic / Implant Dentistry

Date _____

Introducing _____ DOB _____

Address _____

_____

Home Phone _____ Work Phone _____

Referred by Dr. _____ Phone # _____

Referred to:

( ) **Dr. Alexander Shor** ( ) **Dr. Kavita Shor**

Type of Evaluation Requested:

( ) Comprehensive Prosthodontic Examination
( ) Limited Examination

Radiographs:

( ) Our Radiographs are enclosed
( ) Please take necessary radiographs and send duplicates

Reason for Referral:

_____

_____

_____

_____

Patient's Concerns:

_____

_____

_____

FAX OR MAIL TO DR. SHOR