

# *Aesthetic & Implant Centre*

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DDS (Swe) Dipl Impl Dent, MSc Impl Dent (Eng) War

## *Patient Details*

Name.....

Address.....

.....

Postcode..... Telephone.....

Date of Birth.....

## *Nature of Clinical Problem*

Single tooth replacement

Fixed bridge

Denture stabilization

Full fixed reconstruction

Bone graft

Tissue graft

Other

## *Relevant Medical History/Details of Clinical Problem*

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.....  
.....

## *Referring Practitioner*

Name.....

Address.....

.....

Postcode..... Telephone.....

Would you like to be involved with the treatment?     yes     no

## *Radiographs:*

Sending with patient

please take

Signed; .....

Date; .....