Gordon E. Krueger DDS, MS, PA

Certified Prosthodontist

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Patient's Name: _____ Date: _____

Referred By: _____ Phone #: _____

Appointment Date & Time: _____

Reason for referral: _____

_____

_____

X-Rays Enclosed: ❑ Yes ❑ No

REASON FOR REFERRAL

❑ Consult

❑ Crown/Bridge

❑ Dentures

❑ Overdenture

❑ Implant Services

❑ Advance Wear

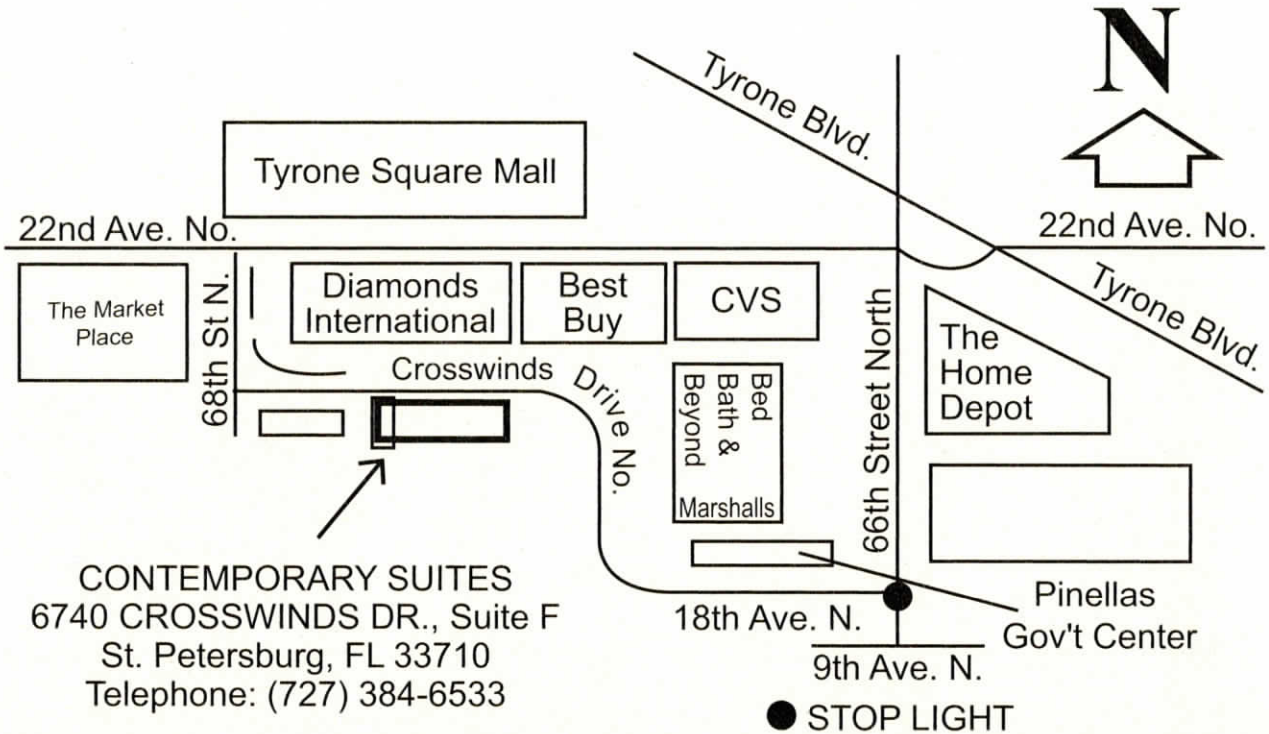
❑ Restoration

❑ Maxillofacial

❑ Repair

❑ Other _____

_____

(Map on reverse Side)

GORDON E. KRUEGER, D.D.S., M.S., P.A.