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Prosthodontist

Member: ADA, MDA, GSLDS **Diplomate:** American Board of Prosthodontics
Fellow: American College of Prosthodontists, American College of Dentists

Patient Referral Form

Date: _____

Patient's Name: _____

Phone: Home _____ Work _____ Cell _____

Tooth(Teeth) to Be Evaluated: _____

Referring Doctor: _____

- Fixed Prosthodontics
- Removable Partial Prosthodontics
- Removable Complete Prosthodontics
- Implant Prosthodontics
- Temporomandibular Joint Disorder
- Esthetic Dentistry
- Second Opinion/Consultation

Comments: _____

