



# TrailheadDental

Implants and Prosthodontics

**Austin Leong DDS, MS**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

**Patient Contact Information:**

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

**Appointment:**

- Already scheduled
- Please contact patient
- Patient will contact Trailhead Dental

Date \_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Radiographs:**

- Emailed to: **frontdesk@trailheaddental.com**
- Mailed
- Sent with Patient
- None Available

**Consult Report:**

- In-writing, via mail
- In-writing, emailed to: \_\_\_\_\_
- By phone

Referred By (Please Print) \_\_\_\_\_

Doctor Signature \_\_\_\_\_

Referring Doctor Phone Number: \_\_\_\_\_