Doctor Referral Form

Nashville Dentures & Implants
504 Collins Park Drive, Nashville, TN 37013
Phone: 615-544-3000 · info@nashvilledenturesandimplants.com

Thank you for trusting us with your patient. Complete this form, attach recent radiographs, and send it by secure email or with the patient. We will contact the patient within 1–2 business days and send you a report after the consultation. **Fields marked * are required.**

REFERRING PROVIDER & PATIENT INFORMATION

Referring dentist*		**Patient name***	
Practice name*		**Date of birth***	
Address		**Phone***	
Phone*		**Email**	
Fax		**Address**	
Email		**Preferred language**	
NPI #		**Insurance / Member ID**	
Office contact		**Accommodations†**	

† e.g., wheelchair access, interpreter, ASL, large print, hearing assistance

REASON FOR REFERRAL (check all that apply)

☐ Consultation / evaluation only
☐ Full-arch implants (All-on-X): U / L / Both
☐ Partial denture
☐ Bone grafting / ridge preservation
☐ Single-tooth implant(s)
☐ Implant-retained or -supported denture
☐ Denture reline, repair, or replacement
☐ Failing implant or prosthesis
☐ Multiple implants / implant bridge
☐ Complete denture: U / L / Both
☐ Extraction(s)
☐ Other: _____

Teeth involved (ADA Universal Numbering) — circle:

Upper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Lower	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Tooth numbers / areas: _____ CDT codes (optional): _____

CLINICAL INFORMATION

Medical history:

☐ Diabetes
☐ Bisphosphonate / antiresorptive meds
☐ Antibiotic premedication required
☐ Cardiovascular disease / high BP
☐ Head/neck radiation
☐ Allergies: _____
☐ Anticoagulant / antiplatelet therapy
☐ Tobacco / nicotine use
☐ Other: _____

Current medications: _____

Clinical notes: _____

_____

Records enclosed:

☐ Panoramic (date: _____)
☐ Intraoral photos
☐ PA / bitewings (date: _____)
☐ Perio charting
☐ CBCT (date: _____)
☐ Treatment notes

SCHEDULING & COMMUNICATION

Urgency: ☐ Routine ☐ Soon (within 2 weeks) ☐ Urgent — please call our office

After treatment: ☐ Return to referring office for general care ☐ Return for final restoration ☐ Treat fully at NDI

Send reports by: ☐ Fax ☐ Secure email ☐ Mail

_____ _____ _____
Referring dentist signature* Printed name* Date*

Patient acknowledgment (optional): I agree to this referral and to have my dental records shared with Nashville Dentures & Implants.

Patient signature: _____ Date: _____

Privacy: This form contains protected health information. HIPAA (45 CFR 164.506) permits providers to share information for treatment without separate patient authorization; it is also handled in line with Tennessee patient-privacy law. Send only by encrypted email or sealed mail. If received in error, call 615-544-3000 and destroy all copies. **Accessibility:** Nashville Dentures & Implants complies with the Americans with Disabilities Act and Section 1557 of the ACA. We offer accessible facilities and free language and communication help, including interpreters, ASL, and large-print or accessible digital versions of this form. Call 615-544-3000.

OFFICE USE ONLY: Received _____ Patient contacted _____ Consult date _____ Report sent _____