



**Center for Advanced Aesthetic
& Implant Dentistry**

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INTRODUCING: _____

Address: _____

Phone: _____ Appointment: _____ AM / PM

RECOMMENDATION

☐ Consultation Regarding _____

☐ Complete Evaluation _____

☐ Dental Implants _____

☐ Other _____

RADIOGRAPHS

☐ Enclosed, find all radiographs available from my office

☐ I have no radiographs, please take what you will need

☐ Other available records

COMMENTS _____

☐ Please call the patient

☐ Patient will call

☐ Please report – Written

☐ Please report – By Phone

Post-Referral Maintenance: ☐ By Specialist

☐ In This Office

☐ To Be Discussed

Referred by: _____

Phone: _____

Date: _____