Carolina
RESTORATIVE & IMPLANT DENTISTRY

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ROBERT D. HOLLAND, JR., DMD | *SPECIALIST IN PROSTHODONTICS*

Please help us best serve you and
your patient by providing the following information:

Patient Name & Phone: _____

Appointment Date & Time: _____

Referring Doctor & Phone: _____

Radiographs:

____ FMX _____ (Date Taken) ____ Panorex _____ (Date Taken)

____ BWX _____ (Date Taken) ____ PA's _____ (Date Taken)

____ Emailed ____ Mailed ____ No Current Radiographs

Reason for Referral:

____ Implant Consult ____ Hybrid Implant Prosthesis Consult

____ Restorative Consult ____ Implant/Restorative Consult

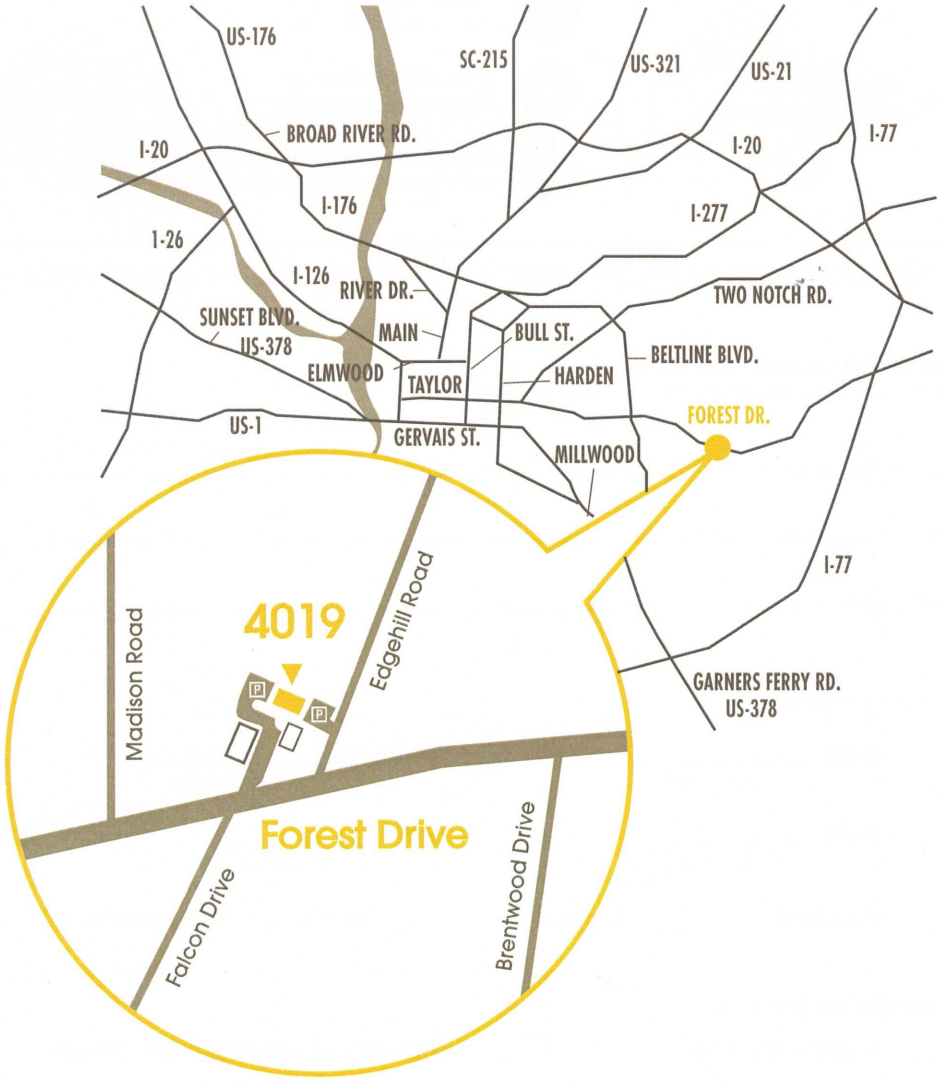
Please give any history or information which you feel will be
helpful as well as any specific areas of concern:

_____

_____

_____

Please fax a copy of this form to
our office (803-787-5416) and give original form to patient



NOTE TO PATIENTS!

PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
WE DO NOT ACCEPT ASSIGNMENT OF INSURANCE.
& PLEASE BRING THIS REFERRAL SLIP WITH YOU

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