

**Riad Almasri, DDS, FICOI**

11970 N. Central Expressway, Suite 430

Dallas, Texas 75243

P:(214) 521-5900

F:(214) 521-8065

## Request for Consultation

Patient Name:	Patient Phone #
Referring Doctor:	Referring Doctor Phone #
Purpose: <input type="checkbox"/> Dental Implants <input type="checkbox"/> Wisdom Teeth <input type="checkbox"/> Extraction <input type="checkbox"/> Other	
XRAY: <input type="checkbox"/> Mailed <input type="checkbox"/> Patient Delivered <input type="checkbox"/> Emailed	<input type="checkbox"/> Sedation Preferred
Notes:	

\*\*\*Patients: Please bring this form to your Consultation

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

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*(Indicate affected teeth)*

