



**DR. SCOTT SKINNER**  
PROSTHODONTIC  
DENTAL SPECIALIST

3804 1/2 Park Ave Wilmington, NC 28403

Phone: 910-452-3369 Fax: 910 452-3486

NEW PATIENT REFERRAL FORM

REFERRING DOCTOR: \_\_\_\_\_ DATE: \_\_\_\_\_

PRACTICE NAME: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ HOME: \_\_\_\_\_

EMAIL: \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

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

Complete Dentures  Upper  Lower

Partial Dentures  Upper  Lower

Immediate Dentures  Upper  Lower

Crowns/Bridges # \_\_\_\_\_

Veneers # \_\_\_\_\_

Maryland Bridge # \_\_\_\_\_

Implant Restoration # \_\_\_\_\_

Multiple treatment plan \_\_\_\_\_

Radiographs  please take  FMX being sent  prior to X-rays being available  Pano.

**\*Once the referral has been received by Dr. SKINNER, our office will call to coordinate an appointment**

PLEASE EMAIL THIS FORM WITH ANY ADDITIONAL INFORMATION TO:

**SCOTTSKINNERDDS@GMAIL.COM**

OR FAX TO: **910-452-3486**