



**FIGRELLA POTESTA-KNOLL**  
DDS, MS

Prosthodontics | Dental Rehabilitation  
Implant Reconstruction

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Email: [Patientcare@goldengatedentist.com](mailto:Patientcare@goldengatedentist.com)

Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

Area Of Maxillary Resection And Reason For Referral: \_\_\_\_\_

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- Immediate Obturator
- Interim Obturator
- Definitive Obturator
- Denture
- Palatal Lift
- Facial Prosthesis
- Nose
- Ear

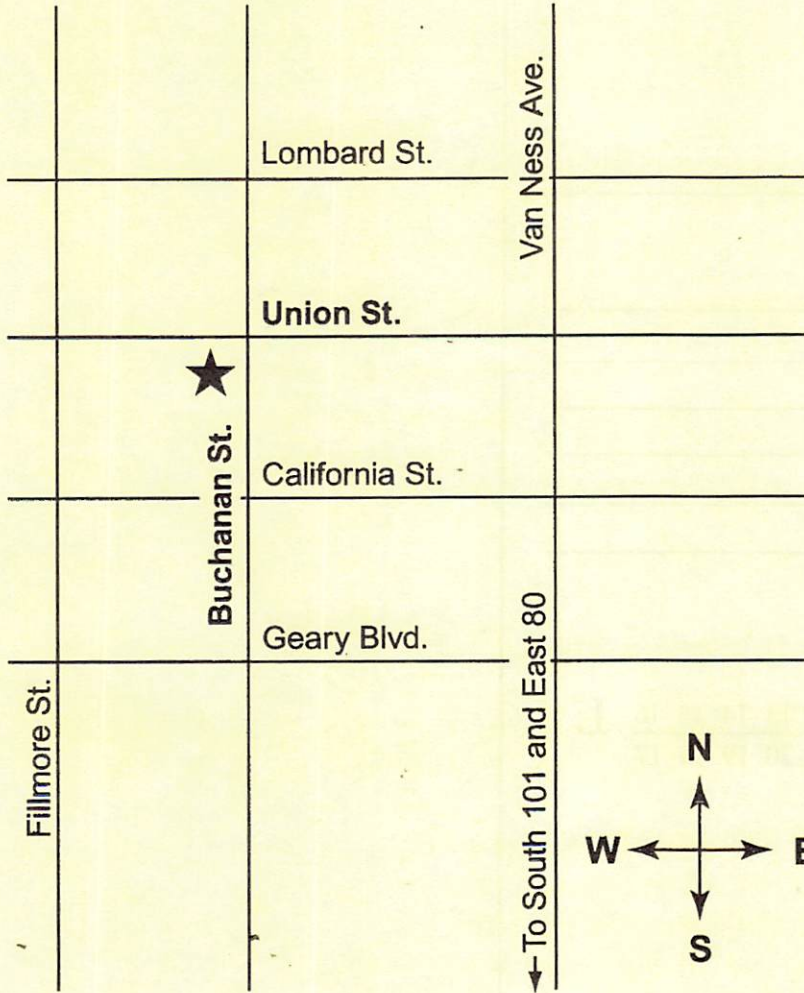
Thank You. Referring Dr. \_\_\_\_\_



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DATE: \_\_\_\_\_ PATIENT'S NAME: \_\_\_\_\_

REASONS FOR REFERRAL: \_\_\_\_\_

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

AREAS OF SPECIAL CONCERN:

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

- DIAGNOSTIC RECORDS ENCLOSED
- PATIENT WILL BRING RECORDS
- CALL BEFORE PATIENT IS SEEN
- CONTACT PATIENT TO ARRANGE APPOINTMENT
- PATIENT WILL CALL FOR APPOINTMENT

THANK YOU. REFERRING DR. \_\_\_\_\_