Today's Date: ______________________

REFERRED TO:
Dr. Greg Kewitt
474 Windmere Drive, Suite 202 814.235.7700 (P)
State College, PA 16801 814.235.7633 (F)

Patient's *Legal* Name: ____

Home Phone: ____________________________Work/Cell Phone: _________________

Date of Birth: ____________________________

Diagnosis: ____

Reason for the Visit:

☐ Extractions

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

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

☐ Implant Guide Stent (please circle): YES NO

☐ TMJ ____

☐ Orthognathic (specify): ____

☐ Other (specify): ____

____

THE FOLLOWING IS ENCLOSED FOR THIS PATIENT

☐ Panoramic X-ray ☐ Models
☐ Cephalogram ☐ Photos

☐ Sent via mail ☐ Sent via email ☐ Sent with Patient ☐ Not available

_________________________________ _________________________________
Print Doctor's Name Referring Doctor's Original Signature

TO BETTER SERVE YOUR PATIENT, PLEASE LET US KNOW IF YOU ARE UNABLE TO EMAIL/FAX OR MAIL THIS REQUEST WITH RECORDS BEFORE THEIR APPOINTMENT.