

Dr Boris Cherkasski  
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PROSTHODONTISTS



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Date \_\_\_\_\_

### *Referring dentist*

Dr: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### *Patient information*

Mr. Mrs. Miss. Ms. \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Date of birth \_\_\_\_\_ Contact phone: \_\_\_\_\_

### *Clinical notes*

**Please examine and:**

Treat as necessary

Provide opinion

**Enclosed:**

Radiographs

Models