

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Referred by: \_\_\_\_\_

Introducing: \_\_\_\_\_ Email: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

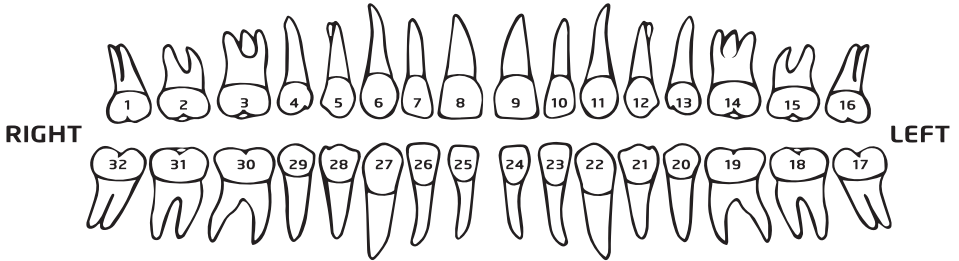
Patient is scheduled on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ at \_\_\_\_\_  am /  pm

Patient will call for an appointment

Please call patient to schedule an appointment

Patient should return for hygiene/maintenance every \_\_\_\_ months

**Radiographs:**    Mailed    Sent with patient    Emailed    Take x-rays



**Consultation for:**

- Implants
- Crown & Bridge
- Veneers
- Complete / Partial Dentures
- Full Mouth Reconstruction
- Radiographic    Surgical Guide
- Sleep Appliance
- Other

Remarks:

Signed: \_\_\_\_\_



# Columbia Smiles

FAMILY DENTISTRY & PROSTHODONTICS

**DR. MICHAEL HSU, DDS, MS, FACP**  
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