Maria Chartzoulakis DMD
Diplomate of the American Board Of Prosthodontics

Referring Dentist: _____ Phone #: _____ Fax #:_____

Patient's Name: _____ Patient's Phone #: _____

Chief Concern/Complaint _____

Past Dental History: _____

Special Concerns: _____

Prosthodontic Care May Be Required: Check All That Apply

☐ Complete Denture: (circle one: upper / lower / both) ☐ Partial Denture: (circle one:upper /lower/both)

☐ Immediate/Interim Denture: (circle one: upper / lower/ both)

☐ Overdenture: (circle one: upper /lower / both

☐ Emergency: ☐ Broken Denture Base ☐ Broken Denture Tooth ☐ Broken Clasp

☐ Reline to Existing Denture

☐ Other (Specifiy): _____

Fixed Prosthodontics:

☐ Crown #: _____ ☐ Bridge (Fixed Partial Denture) _____

☐ Post and Core/Build up #: _____ ☐ Veneer #: _____

☐ Inlay #: _____ ☐ Onlay #: _____

☐ Emergency (Specify): _____

☐ Other (Specify): _____

Implant Prosthodontics:

☐ Single tooth #: _____ ☐ Multple teeth #: _____

☐ Implant Supported Prosthesis #: _____

685 Main St So
Southbury, CT 06488
Phone #: (203) 264-8500 Fax #: (203) 264-8502
Email: dr.chartzoulakis@gmail.com

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Reconstruction: circle one Full Mouth / Partial Mouth):

☐ Teeth Involved #: _____

Patient's Vertical Dimension of Occlusion is:

☐ Excessive (Needs to be Decreased) ☐ Reduced (Needs to be Increased)

Miscellaneous:

☐ Demanding Patient (Give brief History) _____

☐ TMD Complaint Give brief History) _____

Please Fax or Email Completed Form To:

Fax #: (203) 264-8502

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