

# Dr. Michael Yeh, DDS, MSD

## Implant Surgeon & Prosthodontist



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### PRIMARY INFORMATION

REFERRED BY DR.	DATE
PATIENT NAME	DATE OF BIRTH
PATIENT'S HOME	PATIENT'S CELL

### REFERRAL INFORMATION

Patient is referred for (check all that apply)

- |   |                                  |   |
|---|----------------------------------|---|
| <input type="radio"/> Full Mouth Restoration    | <input type="radio"/> Sinus Lift | <input type="radio"/> Implant Placement   |
| <input type="radio"/> Crown/Fixed Bridge        | <input type="radio"/> Bone Graft | <input type="radio"/> Implant Restoration |
| <input type="radio"/> Veneers                   | <input type="radio"/> Extraction | <input type="radio"/> All-on-X            |
| <input type="radio"/> Complete/Partial Dentures |                                  |   |

### COMMENTS

Please indicate treatment alternatives that have been discussed and additional information regarding management, medical conditions, etc. Thank you!

### RECORDS AVAILABLE

- |                                   |                                  |                                |
|-----------------------------------|----------------------------------|--------------------------------|
| <input type="radio"/> RADIOGRAPHS | <input type="radio"/> PERIOCHART | <input type="radio"/> PICTURES |
|-----------------------------------|----------------------------------|--------------------------------|

Please forward any pictures and/or radiographs to [seatac.family.dental@gmail.com](mailto:seatac.family.dental@gmail.com) or have patient to bring a copy of their records