



# Aesthetic Dental Center

**Krysta Sellers DMD, MSD**  
PROTHODONTIST

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Date \_\_\_\_\_ Referring Dr. \_\_\_\_\_

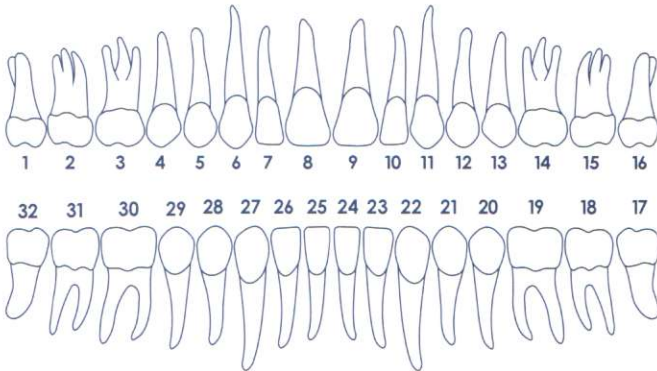
Patient Name \_\_\_\_\_

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

Appointment Date & Time \_\_\_\_\_

Patient will call you for appointment

Please call patient for appointment



Occlusal Wear  TMJ  Dentures  Implants  Partial

Crown/Bridge  Veneers  Sleep Apnea Appliance  Obturator

Pre-cancer Treatment Evaluation  Full Mouth Rehabilitation

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Radiographs Sent: \_\_\_\_\_ Date Xrays Taken: \_\_\_\_\_

Insurance: \_\_\_\_\_

Please return pt to office after treatment