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Introducing: _____

Phone: _____

Referred by: _____ Date: _____

May one of our doctors reach out to the patient personally? YES NO
(If yes, please provide our clinic with a copy of this form)

REASON FOR REFERRAL

- Consultation
- Full Arch (AOX) Implants
- Teeth + Implants Rehabilitation
- Extraction + Graft + Implant

Additional Notes/Comments

Please Return Patient:

- Final Restoration
- Continuing Care
- Hygiene/Maintenance

Scan to see our smile gallery & schedule a consultation!
or visit www.greatlakesimplantcenter.com/

*Our team provides state of the art smile rehabilitation
utilizing the latest technology in a relaxing environment.*

