

MORE SMILES OF BEVERLY  
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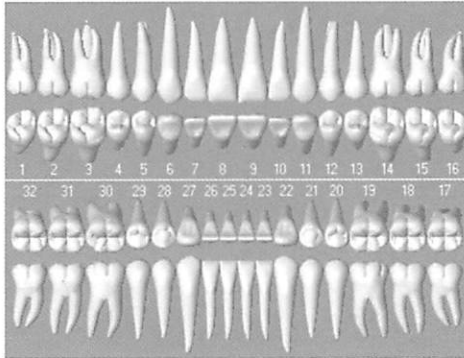
Referring Doctor \_\_\_\_\_ Date: \_\_\_\_\_

Client Name \_\_\_\_\_

Phone \_\_\_\_\_

D.O.B. \_\_\_\_\_

IMPLANTS



Please indicate tooth/teeth requiring treatment: \_\_\_\_\_

Description of the problem and reason for the referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_