DENTAL REFERRALS

For cosmetic and restorative dentistry, dental implants and orthodontic referrals please complete the form below and either send it by post or fax to 01992 552415.

Please call us to arrange an appointment for your patient on 01992 552115 or we can contact your patient directly.

We assure you that we will only provide care/advice for what you are referring your patient for. We are committed to providing an excellent standard of dental care, and returning your patient to your Practice for ongoing care and maintenance.

REFERRING PRACTITIONER

Name

Address

Postcode

Email

Telephone

PATIENT DETAILS

Title

First Name

Last Name

D.O.B. dd/mm/yy

Address

Postcode

Email

Telephone Home

Work

Mobile

CONTACT THE PATIENT DIRECTLY

I authorise the Perfect Smile Studios to contact the Patient directly

Print Name

Signature

REASON FOR REFERRAL

- ☐ Cosmetic dentistry
- ☐ Implants and final restoration
- ☐ Implants only
- ☐ Orthodontics
- ☐ Endodontist
- ☐ Periodontis
- ☐ Worn / CompromisedTeeth

CASE DESCRIPTION

Please: ☐ Investigate and treat ☐ Give your opinion

Chief Complaint

Additional Details / Requests:

Skeletal Class:

☐ Class 1 ☐ Class 2 ☐ Class 3

TMI Symptons:

☐ Nil ☐ Left ☐ Right

Relevant Medical History:

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