GENERAL REFERRAL FORM

STUDIO 1
51 ST. PAUL'S SQUARE
BIRMINGHAM B3 1QS
info@dazzlingsmile.co.uk
0121 233 0867

REFERRING DENTIST

NAME:		REFERRAL DATE:	
PRACTICE:			
ADDRESS:			
		TEL:	
POSTCODE:		E-MAIL:	

PATIENT INFORMATION

NAME:		DOB:	
ADDRESS:		TEL (HOME):	
		TEL (MOBILE):	
POSTCODE:		E-MAIL:	

RELEVANT MEDICAL HISTORY

(Please send a copy of medical history forms if available)

TYPE OF REFERRAL

- ☐ REGULAR PATIENT TO YOUR PRACTICE
- ☐ NEW PATIENT TO YOUR PRACTICE
- ☐ RADIOGRAPHS ENCLOSED
- ☐ STUDY MODELS ENCLOSED
- ☐ PHOTOGRAPHS ENCLOSED

REASON FOR REFERRAL

- ☐ IMPLANT CONSULTATION
- ☐ PERIODONTOLOGY CONSULTATION
- ☐ SEDATION/ NERVOUS PATIENT
- ☐ TMD/ FACIAL PAIN
- ☐ FACIAL AESTHETICS
- ☐ ORAL SURGERY
- ☐ ORTHODONTICS

HISTORY OF PRESENTING PATIENT

(Please specify areas of treatment you may wish to observe if appropriate)

IF YOU WOULD LIKE TO DISCUSS THE PATIENT FURTHER PRIOR TO THE APPOINTMENT, PLEASE REQUEST A PHONE CALL FROM ONE OF OUR DENTISTS

SIGNED……DATE…….