

Patient Referral Form

PATIENT NAME: _____ DATE: _____

REFERRING DOCTOR: _____

REASON FOR REFERRAL: _____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
A B C D E F G H I J

T S R Q P O N M L K
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

- | | | |
|---|---|---|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> IV Sedation/Anesthesia | <input type="checkbox"/> Dental Implant |
| <input type="checkbox"/> Extraction | <input type="checkbox"/> Botox/Facial Fillers/Kybella | <input type="checkbox"/> Nobel |
| <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> Pre-Prosthetic Surgery | <input type="checkbox"/> Straumann |
| <input type="checkbox"/> Bone Grafting | <input type="checkbox"/> TMJ Problems | <input type="checkbox"/> Neodent |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> X-rays given to patient | |
| <input type="checkbox"/> Exposure and Bonding | | |

PATIENT INSTRUCTIONS

1. If sedation is requested please bring a responsible adult with you to drive you home. No food or liquid including water by mouth 8 hours prior to your appointment. No nail polish or artificial nails.
2. Please bring referral slip at time of appointment and any available x-rays.
3. Please bring all medical and dental insurance information with you.
4. Bring a list of all medications taken daily.
5. 48 hours notice is required for all appointment cancellations.
6. Please wear gym shoes and loose fitting t-shirt.