DAWSON DENTAL

PATIENT REFERRAL FORM

REFERRAL DATE

Date (YYYY-MM-DD): _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth (YYYY-MM-DD): _____

Home Phone: _____ Cell Phone: _____

Email: _____

REFERRING DOCTOR

Office Name: _____ Dentist's Name: _____

Phone: _____ Email: _____

REASON FOR REFERRAL

Please check all that apply.

- ☐ Specific Area Examination
- ☐ Gum Grafting
- ☐ Dental Implants
- ☐ Periodontal Disease Treatment
- ☐ Bone Grafting
- ☐ Multiple Areas / Comprehensive Examination
- ☐ Crown Lengthening
- ☐ Pocket Reduction Surgery
- ☐ Sedation – Oral, Nitrous Oxide (N2O), or IV
- ☐ Other: _____

REMARKS / SPECIAL INSTRUCTIONS / NOTES

_____

_____

_____

TEETH / AREAS OF CONCERN

Upper: 18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28

Lower: 48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38

RADIOGRAPHS / LAB REPORTS / ATTACHMENTS / CBCT

- ☐ Attached with this form
- ☐ Please take radiographs / CBCT as required
- ☐ Given to the patient

Date Radiographs / CBCT Were Taken (YYYY-MM-DD): _____