dentalfx
implants and cosmetic dentistry

Referring Dentist

Name ______________________

Name of Practice ______________________

Address ______________________

Phone No ______________________

Email ______________________

Patient Details

Name ______________________

D.O.B ______________________

Address ______________________

Phone (Home) ______________________

Phone (Work) ______________________

Mobile ______________________

Proposed Treatment:- Relevant Dental Conditions

____

____

____

Reason for referral

- ◯ Implant placement only
- ◯ Implant and restoration
- ◯ Bone Augmentation
- ◯ Sinus Augmentation
- ◯ Soft Tissue Augmentation
- ◯ Periodontics
- ◯ Other treatment (please specify) ______________________

Dentists Signature ______________________

Referring Dentist will / will not * provide any necessary temporary restorations

* Delete as appropriate

Dental FX: Implants and Cosmetic Dentistry
84 Drymen Road Bearsden Glasgow G61 2RH
Tel: 0141 931 5533 Fax: 0141 942 1577 Email: info@dentalfx.co.uk
www.dentalfx.co.uk