WATER ORTON
DENTAL CENTRE

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DENTAL IMPLANTS REFERRAL FORM

PATIENT DETAILS

Title: Mr / Ms / Miss / Mrs	Name:
Date of Birth:	Address:
	Phone:
Email:	

RELEVENT MEDICAL/DENTAL HISTORY

Please give details of any medical conditions and medications:

CLINICAL SITUATION (please circle)

Failing Endodontics	Failing Crown & Bridge	Tooth Fracture
Unrestorable Teeth	Unstable Dentures	Aesthetics

Is further treatment planned prior to implant related treatment? Yes / No

If yes, please provide detail:

TEETH/SPACES TO BE TREATED

7	6	5	4	3	2	1	1	2	3	4	5	6	7
7	6	5	4	3	2	1	1	2	3	4	5	6	7

Has the patient been made aware of our price list? Yes / No

Do you wish to carry out the restorative work? Yes / No

Does the patient require sedation or general anaesthetic? Yes/ No

REFERRING DENTIST DETAILS

Name:	Phone:
Email	Address:
	Postcode:

SIGNATURE: **DATE:**