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REFERRING DOCTOR'S

Date : ____ / ____ / ____

Name : _____ Email : _____

Phone : _____ Fax : _____

Preferred contact method : ☐ Phone ☐ Fax ☐ Email ☐ Other _____

Preferred contact date : ☐ Before treatment ☐ After treatment ☐ Both

PATIENT'S

Name : _____ Phone : _____

Email : _____ Date of last cleaning : _____

Sig med hx (diabetes/heart conditions/blood thinners) : _____

Sig dental hx : _____

Reason for referral : _____