Gentle Dental Care

# Gentle Dental Referrals

To book a referral please this complete this form and return it by post or email.

## Patient Details

Name

Address

Post Code

Mobile Phone

Other Phone

Email

Date of Birth

## Referred By

Name

Practice Name

Address

Post Code

Phone

Email

Date

## Treatment Requested

Please include any information that may affect the provision of treatment.

| | | |
|---|---|---|
| Relevant radiographs enclosed | Yes ☐ | No ☐ |
| If implant treatment is requested would you like to restore the implants yourself? | Yes ☐ | No ☐ |
| Is sedation requested? | Yes ☐ | No ☐ |

**Thank you for your referral**. We will offer your patient our best service and return them to your care. If you would like to discuss any aspect of the treatment including restoring implants or any technical points, you are welcome to call or visit at any time.


DENTISTS

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