SONRÍA
DENTAL CLINIC

CONFIDENTIAL

IMPLANTS Specialist Referral Form

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Please take a photocopy of this form before you return it to us

Referring General Dental Practitioner details:

Name: _____

Job Title: _____

Practice: _____

Address: _____

_____ Postcode: _____

Tel(s)/ext.: _____

Date of referral: D D / M M / Y Y Y Y

Preferred clinician: **Ricardo Rosales**

Patient's details (BLOCK CAPITAL LETTERS PLEASE):

Title: Mr/Miss/Mrs/Ms/Other: _____ Date of Birth*: D D / M M / Y Y Y Y

Surname*: _____ First name*: _____

Gender: Male / Female

Address*: _____

_____ Postcode*: _____

Mobile*: _____ Telephone: _____

Email*: _____

DENTAL HISTORY

Oral hygiene (circle): Poor / Fair / Good

Relevant information:

Reason(s) for referral:

Significant orthodontic abnormality ☐
Already wearing appliances ☐
Other ☐

If other, please give details below:

_____
_____
_____
_____
_____

Enclosure(s):

Radiographs ☐ Medical history ☐ Other ☐

My dentist has explained why I / my son / daughter has been referred for an orthodontic assessment. I understand what is involved and am interested in having any necessary orthodontic care.

Patient's / Parent's signature: _____ **Date:** D D / M M / Y Y Y Y