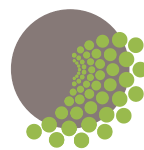

For: Implants, Cosmetic Dentistry, Endodontics, Periodontics, Orthodontics, Dental Imaging, Intra-venous Sedation

Referral Form

Patient's name ______________________ Date of birth ______________

Address ______________________

____

Contact numbers: Home ______________ Mobile ______________

Area to be considered for treatment

- ◯ Implant Clinical Assessment
- ◯ CT scanning services only with copy on CD
- ◯ Implant placement and restoration
- ◯ Implant placement and refer back for restoration
- ◯ Cosmetic dentistry
- ◯ Endodontics
- ◯ Periodontics
- ◯ Orthodontics

Reason / specific problems to address

What you would like us to address and what you would like us to refer back to you

____

____

Referring Dentist ______________________

Practice address ______________________

____

Telephone number ______________________

Signed ______________________ Date ______________

Thank you for your referral

Sending this form back

By post
The Sandford
Implant & Cosmetic Centre
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Bexleyheath
Kent DA6 8AA

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