**Affinity Dental Care & Implant Centre**

**Referral Form**

**Referral Requirements** *(please circle all the apply):*

Dental Implants Pin Hole Surgical Technique for gum recession Adult Braces/ orthodontics X-rays (OPG/ CBCT Scan /OPT) Bio Clear / Cosmetic Treatment Laser Perio Treatment Laser treatments (e.g. tongue tie, frenectomy) Snoring/Sleep Apnoea OSA Direct Access/ Hygiene

**Medical History** *(please include any relevant information regarding the patient’s medical history)*:

**Referral Information** *(please include reason for referral and particular problem area):*

**Patient Details:**

Name: Title:

Address:

 Post Code:

Telephone: Mobile:

Email:

Date of Birth:

**Referring Dentist Details:**

Name and Practice Address:

 Post Code:

Telephone: Mobile:

Email

**Date:**