# Oral & implant surgery referral form

CORNER HOUSE
DENTAL

## Patient details

| First Name: | Surname: | Mr / Mrs / Miss / Ms | Date of birth: |
|---|---|---|---|
| Address | | | |

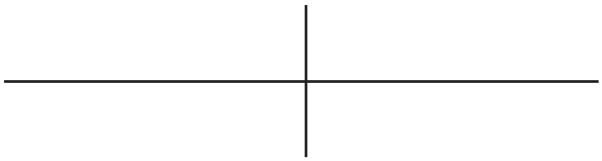
| Tel No: | Home | Work | Mobile |
|---|---|---|---|

### Referral for oral surgery

- ☐ Extraction
- ☐ Apicectomy
- ☐ Tooth Exposure
- ☐ Soft Tissue Surgery
- ☐ Crown Lengthening
- ☐ Sedation

### Referral for implant surgery

- ☐ Patient would like an initial consultation



### Implant surgery to

- ☐ Regeneration surgery
- ☐ Bone grafting
- ☐ Sinus grafting
- ☐ Guide tissue regeneration
- ☐ Referring practitioner to carry out restorative treatment

Presenting problem / Patient's History / Observations:

Medical History:

Smoker: Y / N

Referral From:

Address:

Signature: Date:

ALL PATIENTS REMAIN REGISTERED WITH THE REFERRING PRACTICE.

Corner House Dental Practice 31 Unthank Road Norwich NR2 2PB Telephone 01603 621 613