



Thanet House Dental Care

## Referral Form

Patients name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Contact number Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

### Area to be considered for treatment

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Implant Consultation                           | <input type="checkbox"/> Endodontics  |
| <input type="checkbox"/> Implant placement & refer back for restoration | <input type="checkbox"/> Periodontics |
| <input type="checkbox"/> Implant placement & restoration                | <input type="checkbox"/> invisalign   |
| <input type="checkbox"/> Cosmetic dentistry                             | <input type="checkbox"/> Hygienist    |

### Reason for referral/specific problems to address

What would you like us to address and what would you 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:  
Thanet House Dental Care  
65 Thanet Road  
Bexley  
Kent  
DA5 1AP

By email:  
reception@thanethousedental.co.uk  
  
www.thanethousedental.com  
Tel: 01322 558548