EasySmile
DENTAL PRACTICE
AFFORDABLE QUALITY CARE

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# EASYSMILE ASHFORD & TENTERDEN REFERRAL FORM

• Endodontics • Treatment Under Microscope • Periodontics • Oral & Maxillofacial
• Complex Restorative • Complex Cosmetic • Implants • Digital CT Scan • Orthodontics

**FREE Consultations with a Clinician are available (excludes clinical treatment)**

Please complete all details using BLOCK CAPITALS

**PATIENT** Name: ..... D.O.B (DD/MM/YYYY): .....

Address: .....

Telephone: MOB: ..... H: ..... W: .....

Email: .....

**REASON FOR REFERRAL** (Please tick all that apply):

| | | | | | |
|---|---|---|---|---|---|
| Free Consultation | ☐ | Complex Restorative | ☐ | Implant Placement Only | ☐ |
| Endodontic Treatment | ☐ | Complex Cosmetic | ☐ | Implant & Restoration | ☐ |
| Periodontic Treatment | ☐ | CT Scan & Viewer CD | ☐ | Oral & Maxillofacial Surgery | ☐ |
| Periodontic Maintenance | ☐ | Implant Planning | ☐ | Orthodontics | ☐ |

**REFERRAL REQUEST** (Simply tick):

☐ Please consult and treat as appropriate.

**OR**

**REFERRAL REQUEST** (Alternatively please specify below the referral details i.e. Nature of Problem, Relevant Details and Requests):

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**MEDICAL HISTORY / ADDITIONAL INFORMATION / RADIOGRAPHS:**

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Are relevant radiographs being sent? (Please tick only one) ☐ YES by post ☐ YES by email ☐ NO

**REFERRING PRACTICE** Name & Address: .....

.....

..... Referring Clinician: .....

Practice Tel: ..... Tel: ..... Fax: .....

Practice Email: .....

Signature: ..... Date (DD/MM/YYYY): .....

Upon completing the form please send it along with any relevant radiographs to EasySmile Ashford (see address at top of page).
For an online referral form, additional printable forms or more information visit www.myeasysmile.com and click on "Referrals".