

# PATIENT REFERRAL FORM



*creating beautiful smiles*

[www.clevelandcosmetic.co.uk](http://www.clevelandcosmetic.co.uk)

## PATIENT DETAILS

Title: Mr Mrs Miss Ms Dr Other please specify: \_\_\_\_\_

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Postcode: \_\_\_\_\_

Tel.Home: \_\_\_\_\_ Tel.Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

### The patient is experiencing: (please tick)

- |                      |                          |                    |                          |                 |                          |
|----------------------|--------------------------|--------------------|--------------------------|-----------------|--------------------------|
| Failed Bridgework    | <input type="checkbox"/> | Loose Dentures     | <input type="checkbox"/> | Poor Aesthetics | <input type="checkbox"/> |
| Failed Crown         | <input type="checkbox"/> | Social Problems    | <input type="checkbox"/> | Loose Teeth     | <input type="checkbox"/> |
| Periodontal Problems | <input type="checkbox"/> | Difficulty Chewing | <input type="checkbox"/> | TMJ Problems    | <input type="checkbox"/> |
| Any other problems   | <input type="checkbox"/> |                    |                          |                 |                          |

Teeth Requiring Treatment \_\_\_\_\_

Please specify problems:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please specify any relevant medical history:  
\_\_\_\_\_  
\_\_\_\_\_

Please add any other information you think may be helpful:  
\_\_\_\_\_  
\_\_\_\_\_

## Referring Dentist Details

Name: \_\_\_\_\_

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

Postcode: \_\_\_\_\_

Tel.No: \_\_\_\_\_

### Nature of treatment to be carried out by Cleveland CDIC: (please tick)

- |                                    |                          |                       |                          |                |                          |
|------------------------------------|--------------------------|-----------------------|--------------------------|----------------|--------------------------|
| All treatment requested by patient | <input type="checkbox"/> | All Implant treatment | <input type="checkbox"/> | Smile Makeover | <input type="checkbox"/> |
| Cosmetic treatment only            | <input type="checkbox"/> | Implant surgery only  | <input type="checkbox"/> |                |                          |

Signature of Referring Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

THIS FORM MAY ALSO BE TRANSMITTED VIA OUR WEBSITE

Greenfields House  
Wellburn Road  
Fairfield  
Stockton-on-Tees  
TS19 7PP

Telephone. 01642 570147  
Facsimile. 01642 570870  
Email. [info@cdic.co.uk](mailto:info@cdic.co.uk)