Referral letter

Referring Dental Surgeon: Dr__________________________ Date:_________________________

Practice Name:____

Practice Telephone Number:____

Email Address:____

Practice Address;____

____Post Code:_________________________

Patient Name: Mr/Mrs/Miss____

Date of Birth:____

Home Tel No.:____

Mobile Tel No:____

Patient Address____

____Post Code:____________________________

Medical History:____

____

____

Treatment Requested:____

____

____

We would be happy to contact the patient directly to arrange an initial consultation,when we can plan and quote for the treatment requested by yourself, the referring dental surgeon.

City Dental Practice, 21 High Street , Bangor, LL57 1NP
www.citydentalpractice.co.uk---Email:info@citydentalpractice.co.uk
01248-370054