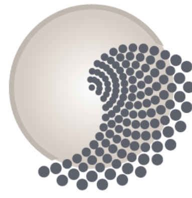

thesandford
dental implant & cosmetic centre

For: Implants, Cosmetic Dentistry,
Endodontics, Periodontics,
Orthodontics, Dental Imaging,
Intra-venous Sedation

Referral Form

Patient's name ______________________ Date of birth ____________

Address ____

____

Contact numbers: Home ______________________ Mobile ____________

Area to be considered for treatment:

- ○ Implant Clinical Assessment
- ○ OPG
- ○ Implant placement and restoration
- ○ Implant placement and refer back for restoration
- ○ Cosmetic dentistry
- ○ Endodontics
- ○ Periodontics
- ○ Orthodontics

Reason/specific problems to address

What you would like us to address and what you would like us to refer back to you

____

____

Referring Dentist

Practice address ____

____

Telephone/Email ____

Signed ______________________ Date ____________

Thank you for your referral

Sending this form back

By post
The Sandford
Implant & Cosmetic Centre
306 Broadway
Bexleyheath
Kent DA6 8AA

By e-mail
info@thesandford.com

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