# Dental Implants Referral Form

Premier Dental Clinic

## PATIENT DETAILS

Name

Date of Birth
dd/mm/yyyy

Contact Telephone N°
main
mobile

Address

Email Address

## TREATMENT REQUESTED

## OTHER TREATMENT REQUESTED

- ☐ Please carry out any treatment necessary prior to implant placement
- ☐ Please liase with referring practice for restorative treatment prior to implant treatment
- ☐ Please invite me to attend implant surgery appointment with my patient

## RELEVANT MEDICAL HISTORY/DENTAL HISTORY

Please give details of any medical conditions and medication

## RELEVANT DENTIST DETAILS

Name

Telephone

Address

Email Address

Signed

Date

Premiere Dental Clinic
77 Beckenham Lane, Bromley, Kent BR2 0DN

Tel: 020 8460 9150
Email: reception@premieredentalclinic.co.uk

www.premieredentaliclinic.co.uk