NORTH COUNTY
COSMETIC & IMPLANT DENTISTRY

REFERRAL SLIP

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ADULT SPECIAL NEEDS • IV SEDATION • IMPLANTS • ORAL SURGERY

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone: _____

Today's Date: _____

REFERRING OFFICE

Doctor/Practice: _____

Contact Person: _____

Phone: _____

Email: _____

☐ Please call to discuss this case

REASON FOR REFERRAL

- ☐ Wisdom Teeth (3rd Molars)
- ☐ Surgical Extraction
- ☐ Biopsy
- ☐ Single Implant
- ☐ Multiple Implants
- ☐ Full Arch Implants
- ☐ Bone Grafting
- ☐ Sinus Lift
- ☐ IV Sedation
- ☐ Special Needs Dentistry
- ☐ Medically Complex Patient
- ☐ Gingival Graft
- ☐ Crown Lengthening
- ☐ CBCT Scan
- ☐ Panoramic X-Ray
- ☐ Implant Restoration
- ☐ Restorative Dentistry

TEETH / AREA OF CONCERN

1	2	3	4	5	6	7	8	9	10	11	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	17



Please circle tooth numbers and indicate treatment area.

CLINICAL NOTES

_____

_____

THANK YOU
FOR YOUR REFERRAL

We truly appreciate your trust and collaboration. We will provide exceptional care and return your patient to your office for ongoing treatment whenever appropriate.