Beachstone Dental | Rejuvenate your smile
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DENTAL REFERRAL FORM

Referring Professional: _____

Facility: _____ Email: _____

Phone: _____ Fax: _____

Address: _____

We are referring the patient:

First Name: _____ Last Name: _____

Date of Birth (M/D/Y): _____ Gender: _____ Marital Status: _____

Home Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone: _____ Work/Alt Phone: _____

Email: _____

Contact Person: (Parent/Guardian if applicable): _____

Has Primary Insurance: Yes No Insurance Company: _____

Has Secondary Insurance: Yes No Insurance Company: _____

Reason for Referral: _____

Relevant History: (Indicate any special factors – either dental, medical, or pharmaceutical – such as known allergies, medications, and specific medical information relevant to diagnosis and treatment.) _____

_____

_____

Comments: _____

_____

_____

- ☐ Please call the patient
- ☐ Patient will call
- ☐ An appointment has been made
- ☐ Radiographs are enclosed
- ☐ Radiographs to be emailed separately
- ☐ Patient will bring radiographs
- ☐ No radiographs are available
- ☐ Other records are available
- ☐ Notify on completion
- ☐ No follow-up report needed

Referring Professional's Signature: _____ Date: _____

Thank you for your referral. Please send all relevant information and radiographs to our office. Please request the patient to bring a valid form of identification, health card, insurance information (our office is non-assignment), and a list of current medications. A report will be sent to the referring doctor following treatment, unless requested otherwise.