DR. BRAD WELSH
& ASSOCIATES
GENERAL • BRACES • IMPLANT
DENTISTRY

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REFERRAL FORM

Date _____

Patient Information

Patient Name _____

Referring Dentist _____

Phone (H) _____; (C) _____

Date of Birth: _____

Medication History

Does this patient require pre-medication before dental treatment? ❑ Yes ❑ No
Does this patient have any known medical conditions? ❑ Yes ❑ No

Clinical Findings

Treatment Desired:

❑ Implant Placement ❑ Implant Placement & Restoration

❑ Date of extraction if not done at this office: _____

❑ IV Sedation ❑ Restorative Treatment

❑ Oral Surgery / Impactions ❑ Special Medical Conditions

❑ Endodontic Treatment

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R																		L
	32	31	30	29	28	27	26	25	L	24	23	22	21	20	19	18	17	

Comments/opinions as to treatment:

Radiograph?
❑ Sending with patient
❑ E-mailed to appointments@drbradwelsh.com
❑ To be taken by this office

Dr. _____