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

	1	2	3	4	5	6	7	8	U	9	10	11	12	13	14	15	16	
R																		L
	32	31	30	29	28	27	26	25	L	24	23	22	21	20	19	18	17	

Comments/opinions as to treatment:

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Radiograph?

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

Dr._____