LEGACY DENTAL™

American Academy of Cosmetic Dentistry MEMBER

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COSMETIC/GENERAL PATIENT REFERRAL FORM

Patient Name: _____ **Date:** _____

Phone Number: _____ **Date of Birth:** _____

☐ Please contact patient ☐ Pt will contact your office ☐ Has appt on: _____

I am referring our patient for the following consultation (please check all that apply)**:**

☐ Smile Design
☐ Ant Composite/Ceramic Treatments
☐ Full Mouth/Arch Rehab
☐ Implant Related Treatment
☐ Other

The patient is requesting the following treatment(s):

_____

_____

_____

The patient has the following medical/dental condition(s) relevant to diagnosis and treatment:

_____

_____

_____

_____

Doctor : _____ **Date:** _____

Phone Number: _____ **Fax:** _____

☐ Exam ☐ 2nd Opinion ☐ Send Report ☐ Call Me ☐ Notify on completion

☐ X-rays given ☐ Please return X-rays. ☐ Other records available

PLEASE RETURN CONSULTATION REQUEST TO:

FAX: 254-774-8368

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