alphahouse
DENTAL PRACTICE & IMPLANT CENTRE
your teeth in safe hands

PRACTICE EXCLUSIVE TO ORTHODONTICS

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BDS 2007; Postgraduate Specialty Training in Orthodontics and Dentofacial Orthopaedics 2011
GDC No. 294874

REFERRAL FORM

PATIENT DETAILS:

Title: DoB (DD/MM/YYYY):
First Name: Surname:
Address:
Postcode:
Tel No (Day): Tel No (Evening):
Email:

Preferred method of contact: ☐ Post ☐ Phone ☐ Email

REFERRAL REQUIREMENTS:

- ☐ Invisalign
- ☐ Fixed Braces (Metal / Ceramic)
- ☐ Lingual Braces
- ☐ Removable Appliances
- ☐ Functional Appliances
- ☐ Interceptive Orthodontics
- ☐ 3M Digital Bonding
- ☐ Other (please specify):

What is Patient's main concern for the orthodontic treatment?

Smoker: ☐ Yes ☐ No Number smoked per day:

PATIENT MEDICAL HISTORY:

Are relevant radiographs being sent? ☐ YES by post ☐ YES by email ☐ NO

REFERRING PRACTICE:

Full Name:
Address:
Tel No: Email:

Signed: **Date:**