DR. MICHAEL N. DANIELAK
Board Certified Prosthodontist
DDS, Cert. Pros, FRCD(C)

NEW PATIENT REFERRAL FORM

PATIENT INFORMATION

Patient Name: ______________________________ Gender: ☐ M ☐ F

Address: ______________________________

Date of Birth: ______________________ Patient Phone: ______________

Patient Email Address: ______________________________

REASON FOR REFERRAL

Consultation Regarding (please indicate specific region using FDI notation):

☐ Compromised Aesthetics ☐ Fixed Prosthetics (Veneer, Onlay, Crown, Bridge)

☐ Compromised Function ☐ Removable Prosthetics (Partial, Complete, Overdenture)

☐ Comprehensive Care ☐ Implants (☐ Placement Only ☐ Place & Restore)

☐ Specific Region / Other: ______________________________

TREATMENT (as requested)

Please provide the specialist with appropriate details of problem (ie, urgency, areas of concern, etc.)

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SIGNIFICANT MEDICAL & DENTAL HISTORY

Indicate any special factors (ex: allergies, medical problems, medications) relevant to diagnosis and treatment

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RADIOGRAPHS

☐ E-mailed (Preferred) ☐ Enclosed ☐ Mailed ☐ Faxed ☐ With Patient ☐ None

APPOINTMENT

☐ Contact patient to schedule ☐ Already scheduled ☐ Patient will call

POST-CONSULTATION COMMUNICATION TO REFERRING DENTIST

☐ DO NOT TREAT; Send written report with findings and proposed plan first, do not start treatment yet

☐ Send written report with findings and proposed plan, then start treatment as needed

☐ No written report required and no follow-up with referring doctor required, start treatment as needed

Referring Dentist Name: ______________________ Date of Referral: ______________

Office Name: ______________________

Office Address: ______________________

Office Phone: ______________________

Office Email: ______________________

OFFICE STAMP

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