✦ serenity ✦
SLEEP DENTISTRY

Thomas E. Clark, | Terrence A. Clark, DMD | Quinn Walker, DDS

Doctor Referral Form

Patient's first name:	
Patient's last name:	
Patient's date of birth:	
Patient's email:	
Patient's phone:	
Patient's preferred method of contact:	○ email ○ phone call ○ text
Doctor's name:	
Doctor's email:	
Doctor's phone:	
Doctor's preferred method of contact:	○ email ○ phone call ○ text
Reason for referral:	☐ gag reflex ☐ dental anxiety ☐ difficulty to anesthetize ☐ medical condition(s), *please list:* ☐ other, *please specify:*
Treatment needed, *please list:*	
How would you designate the patient's future status?	○ patient returns to referring doctor for all future treatment. ○ patient returns to referring doctor for recall only. ○ patient remains with Serenity Sleep Dentistry for all future recall and treatment. *Note all patients are returned to referring doctor unless specifically requested otherwise.