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.

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