

REFERRAL FORM

Date:

DENTIST DETAILS

Name of referring dentist:

Email:

Telephone no:

PATIENT DETAILS

Title: Name:

DOB: Telephone no:

Email:

Address:

Postcode:


Reason for referral:


Implant Dentistry	
Periodontics	
Endodontics	
Restorative Dentistry	
Orthodontics	
IV Sedation	
Facial Aesthetics	
Prosthodontics	
Oral Surgery	
X-rays - OPG, vertical bitewings	

**Please attach any relevant x-rays or images or let us know if you'd like us to take these.
Attach radiograph (file types accepted gif/png/jpeg).**

Ways to send referrals to us - making it an easy process for you!

 You can telephone the practice and speak to Louise our Treatment Coordinator on **0121 354 1922**

 You can use our online website referral portal go to **suttonsmiles.com**

 Whatsapp us the patient information securely to our dedicated practice mobile on **0758787303**

 Scan, upload, email over patient details to Louise **louise@suttonsmiles.com**

Sutton Dental & Implant Clinic, 60 Birmingham Road, Sutton Coldfield, West Midlands B72 1QP
0121 354 1922 • www.suttonsmiles.com

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