Date of referral:

Patient details:

Dr / Mr / Mrs / Miss

Name:

M / F DoB:

Address:

Post Code:

Telephone:

Notes:

The Implant Centre
5 Heath Square, Boltro Road,
Haywards Heath, RH16 1BL
t 01444 474 015
f 01444 474 853
info@theimplantcentre.com
www.theimplantcentre.com

The Implant Centre

Referral Form

Patient details: Dr / Mr / Mrs / Miss

Name:

Male / Female DoB:

Address:

Post Code:

Telephone numbers:

Referring practitioner: Dr / Mr / Mrs / Miss

Name:

Date of referral:

Practice name:

Practice address:

Post Code:

Practice manager:

Telephone number:

Short summary of case:

Area to be considered for implants:

Teeth to be extracted:

Regular practice attender: Y / N

I wish to restore the implant: Y / N

Please fax this form to 01444 474 853 or post to the address below in supplied sae

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Advanced Implant Services Ltd

Date of referral:

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