HAR
DENTAL GROUP

Har Dental Group - Referral Form

PATIENT INFORMATION

First Name	**Last Name**
DOB	**Gender**
Parent/Guardian First Name	**Parent/Guardian Last Name**
Home Phone	**Mobile Phone**
Contact Email Address	**Does the patient require antibiotics prior to dental treatment?**
Please call patient	**Treatment**

REFERRING DOCTOR'S INFORMATION

Referred By First Name	**Referred By Last Name**
Telephone	**Email Address**

PROCEDURES

Extraction (see tooth chart below)	**Alveoloplasty**
Biopsy	**Incision and Drainage**
Lesion Evaluation	**Exposure**
Hard Tissue	**Infection**
Expose and Bond	**Soft Tissue**
Frenectomy	**Apicoectomy**
Other Procedures	

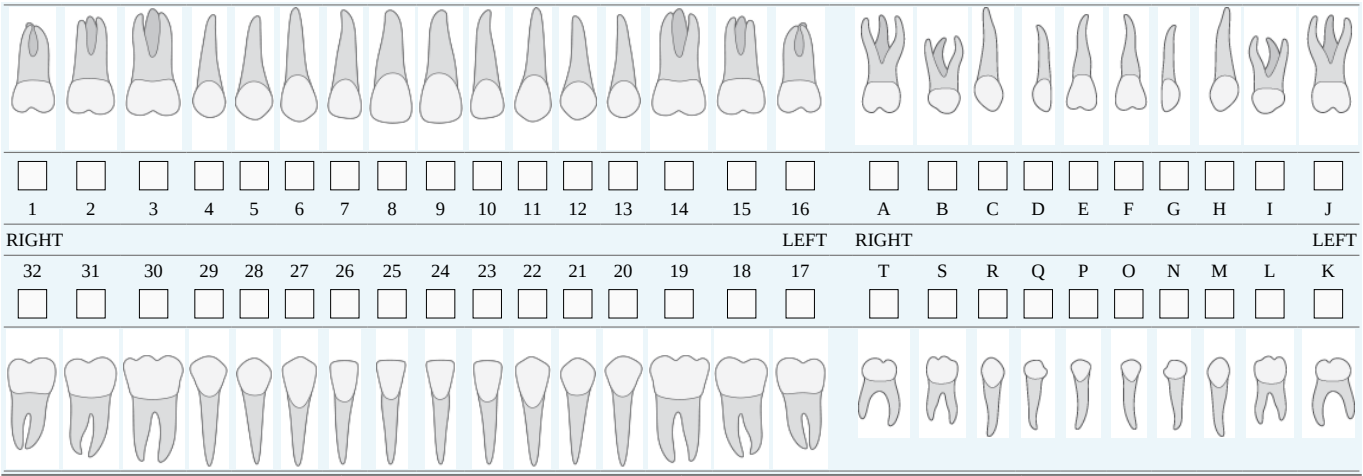
CONSULTATIONS

TMJ	**Implants**
Implants Type	**Orthognathic Evaluation**
Pre-Prosthetic	**Cleft Lip and Palate**
Cosmetic	**Ridge Augmentation**
Oral / Facial Lesion	**Bone Grafting**
Other Consultations	

OTHER CONSULTATIONS

Implants	**Surgical Template**

EXTRACTIONS



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Please verify teeth for extraction

RADIOGRAPHS OR CLINICAL PHOTOS

ATTACH XRAY(S) TO THIS REFERRAL FORM AND MAIL TOGETHER

Radiographs / Clinical Photos **Radiograph/Photos**

If X-Rays are attached, what date were they taken

CASE NOTES

Comments

REVIEWED AND SIGNED BY DOCTOR

This is for doctor use only

Sign