

ALINGTON DENTAL

EST. 1920

CBCT scan OPG and Implant Referral Form

Patient Details:

Name

Address

.....

Postcode

Date of Birth

Telephone

Presenting complaint:

.....

.....

.....

.....

Implant Referral:

What would you like us to do ?

.....

What would you like to do ?

.....

Signed GDC number Date

Referring Dentist Details:

Name

Practice

Reason for referral

.....

.....

.....

Reason for Referral:

OPG

CBCT Maxilla Mandible Both

Region of Interest

Radiographic stent Yes No

ADDRESS
7 Poole Rd, Bournemouth

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01202 763348

WEBSITE
alingtondental.com

