Synergy Specialist Dental & Healthcare
33 Hall Lane
Chingford
London E4 8HH
Tel : 020 8506 3690

Referral Form

Dentist's Name: _____

Dentist's Address: _____

Dentist's Telephone: _____

Dentist's Email: _____

Patient's Name: _____

Patient's DOB: _____

Patient's Address: _____

Patient's Email: _____

Patient's Telephone: _____

Dental Specialty

☐ Prosthodontics ☐ Implants ☐ Oral Surgery ☐ Sedation

☐ Periodontics ☐ Endodontics ☐ Orthodontics

Reason for Referral: _____

Relevant Medical History: _____

Priority ☐ Urgent ☐ Non Urgent

Radiographs Please post radiographs separately.

Signature _____ **Date** _____