RED HOUSE
DENTAL

PATIENT REFERRAL

REFERRAL FORM

Please complete the referring provider and patient details, then select the treatment requested.

Select all applicable treatments. Fields marked with * are required.

REFERRING PROVIDER

Referring Doctor Name *

Clinic Name *

Clinic Address *

Clinic Phone *

Clinic Email *

PATIENT INFORMATION

Patient Name *

Patient Age *

Patient Sex *

- ○ Male
- ○ Female
- ○ Other

Patient Phone *

Patient Email *

REFERRAL DETAILS

Please select all that apply.

- ☐ Sleep apnea appliance
- ☐ TMJ Botox
- ☐ Wisdom tooth removal
- ☐ Implant placement
- ☐ Other treatment

If other, please specify

Additional Message

Please return this completed form using your clinic's approved secure method.