

Patient Referral Form
Please fill-out, then print and fax or send back.

Patient's Name _____

Patient's Telephone

(home) _____

(work) _____

Referred by _____ Date _____

Type of examination requested: (please check all that apply)

- Comprehensive examination
- Mucogingival problems _____
- Prescription surgical procedures _____
- Implants _____
- Crown lengthening _____
- Smile enhancement _____
- Transeptal fiber release or frenectomy _____
- Other _____

Radiographs: (please check all that apply)

- Current x-rays enclosed, sending or digital
- Please take a complete series of x-rays and send a duplicate copy
- Patient has been given recent x-rays

Please fill-out, then print and fax or send back to:

Anderegg & Thomas
14655 Bel-Red Road #202
Bellevue, WA 98007

425-747-7007 Office
425-747-7342 Fax
<https://andereggthomas.com>