

ANDREA UBHI YORK

REFERRAL FORM FOR IMPLANTS

To: Dr Adam Glassford BChD Dip Con Sed(Ncle)
23 Stonegate
York
YO1 8AW

or send by email to:
info@andreaubhi.com
fax to: 01904 613241
tel: 01904 639667

Date of referral:
Patient name:
Address:
Date of birth:
Home Tel:
Mobile:

<u>Reason for referral:</u> Please indicate specific patient concerns if appropriate.
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Referring dentist's details:
Name:
Address:
Phone number:
Fax or email:

Please enclose relevant radiographs, if available. These will be returned to you at the end of the treatment.
Relevant Medical History:

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