ELROD & DUNHAM DENTISTRY

"Where smiles come together"

Referring Dr. _____ Date: _____

Referring Office Info: _____

Patient Name: _____ Patient DOB: _____

Patient Phone Number: _____

Address: _____ City: _____ State: _____

Reason for Referral:

- ☐ CBCT
- ☐ Root Canal
  - Tooth #_____
- ☐ Consult/Treatment Plan
- ☐ Implant
  - Tooth #_____
- ☐ Other

Comments:

_____

_____

_____

_____

_____

_____

X-Rays/Photos taken: ☐ Panorex ☐ PA ☐ BW ☐ Intraoral Photo ☐ None

☐ Emailed

☐ Sent with patient

Referring to Dr: ☐ Elrod ☐ Dunham ☐ Marotta ☐ Nuckols ☐ Maas ☐ Cumins ☐ Tyree

Bell Creek

(804)746-1300

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Goochland

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