SERENITY
DENTAL GROUP

Doctor Referral Form

2510 Stevens Creek Blvd.
San Jose, CA 95128
(408) 999-0444

Referred By Doctor:

Referred Patient:

Parent/Guardian:

Birthdate:

Address:

Telephone:

REASON FOR REFERRAL: ☐ Consultation ☐ Treatment

Please provide appropriate details of problem (i.e. urgency, areas of concern):

RELEVANT HISTORY (Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.):

Call referring doctor before treatment: ☐ Yes ☐ No

Radiographs: ☐ sent with patient ☐ mailed/transmitted ☐ attached ☐ none available

☐ Please provide written report.

SIGNED: _____ DATE: