BAX
DENTAL & IMPLANT CENTRE

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68 King Edward Street, Macclesfield, Cheshire SK10 1AT

Referral Form

DATE

REFERRING DENTIST

PRACTICE ADDRESS

TELEPHONE

POSTCODE

EMAIL

PATIENT NAME

PATIENT REFERENCE

ADDRESS

D.O.B.

TELEPHONE

MOBILE

POSTCODE

EMAIL

RELEVANT MEDICAL HISTORY
(including current medications)

TYPE OF REFERRAL

IMPLANTS ☐ RESTORATIVE ☐ ORAL SURGERY ☐ IV SEDATION ☐

BRIEF DESCRIPTION OF PRESENTING COMPLAINT

Please attach or email any relevant radiographs or study models, quoting patient reference. These will be returned to you after use.

CRAIG JACK
BDS MFDS RCS(Ed) MSc

GAVIN MCMANUS
BDS MFDS RCS(Ed) DipImpDent RCS(Eng)