LANAP
ADVANCED LASER DENTISTRY
TRACEY R. HUGHES, DDS

drtraceyhughes@gmail.com
720-334-3566

PATIENT REFERRAL FORM

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

PHONE _____ EMAIL _____

DATE _____ PREFERRED CONTACT ☐ Call ☐ Text ☐ Email

REFERRAL

REFERRING DOCTOR _____ PRACTICE NAME _____

DOCTOR PHONE _____ DOCTOR EMAIL _____

REASON FOR REFERRAL _____

MEDICAL FLAGS

Hypertension Y N

Heart condition Y N

Blood thinner / anticoagulant Y N

Bisphosphonates Y N

Smoker / tobacco user Y N

Diabetic Y N

CURRENT BLOOD PRESSURE _____ / _____ mmHg

REQUIRED ATTACHMENTS

☐ Current FMX radiographs ☐ Periodontal chart ☐ Current medical history

REQUESTED APPOINTMENT

REQUESTED DATE _____ PREFERRED TIME _____

ALTERNATE DATE / TIME _____