OnlineDoctorReferral

International Center for Dental Excellence
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Online patient registration at drcintron.com
info@drcintron.com

Referral Form

Patient Name:_____

Patient Email:_____

Referred By: _____ **Date:** _____

Please: ☐ **Evaluate** ☐ **Treat** ☐ **Lab Test Results Enclosed**

Patient Clinical Findings:

☐ Allergies	☐ Joint Replacement/Disease
☐ Bacteremia	☐ Kidney or Liver Conditions
☐ Biocompatibility Materials	☐ Lung/Respiratory Disease
☐ Cancer - Type_____	☐ Metal/Amalgam Fillings
☐ Cardiovascular Conditions	☐ Neurological Conditions
☐ Dental Abscess	☐ Scheduled for Surgery
☐ Diabetes	☐ Skin Problems/Infections
☐ Immune Deficiencies	☐ Thyroid Disease

Medications:_____

Comments:_____

_____

Scheduled:

☐ **M** ☐ **T** ☐ **W** ☐ **TH** ☐ **F** **Date:**_____ **Time:**_____

****Together we can provide the best care for our patients****

"Passion for Wellness"