Dr. Peter V. Vanstrom | Dr. Sharon Lee

Comprehensive Dentist

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PATIENT REFERRAL FORM

REFERRING DOCTOR INFORMATION

Referring Doctor: **Date:**

Practice Name:

Phone: **Email:**

PATIENT INFORMATION

Patient Name: **D.O.B.:**

Phone: **Email:**

REASON FOR REFERRAL

- ☐ Comprehensive Dental Evaluation
- ☐ Cosmetic Consultation (Veneers, Smile Design)
- ☐ Restorative / Crown & Bridge Work
- ☐ Implant Consultation / Restoration
- ☐ Periodontal Evaluation
- ☐ TMJ/Occlusion Consultation
- ☐ Second Opinion / Specific Area of Concern

Notes / Specific Instructions:

RADIOGRAPHS & RECORDS

- ☐ Radiographs sent via email (smile@vanstrom.com)
- ☐ Radiographs given to patient
- ☐ Please take new radiographs

Instructions for the Patient:
Please contact Artistic Dentistry of Atlanta at **404-325-2905** to schedule your appointment, or visit **www.artisticdentistryofatlanta.com** to access location details and patient intake forms. Kindly bring this referral form and your dental insurance information with you to your scheduled visit.