**Patient Referral Form**
**Please fill-out, then print and fax or send back.**

Patient's Name _____

Patient's Telephone

(home) _____

(work) _____

Referred by _____ Date _____

**Type of examination requested:** (please check all that apply)

- ☐ Comprehensive examination
- ☐ Mucogingival problems _____
- ☐ Prescription surgical procedures _____
- ☐ Implants _____
- ☐ Crown lengthening _____
- ☐ Smile enhancement _____
- ☐ Transeptal fiber release or frenectomy _____
- ☐ Other _____

**Radiographs:** (please check all that apply)

- ☐ Current x-rays enclosed, sending or digital
- ☐ Please take a complete series of x-rays and send a duplicate copy
- ☐ Patient has been given recent x-rays

Please fill-out, then print and fax or send back to:

**C.R. Anderegg, DDS**
**14655 Bel-Red Road #202**
**Bellevue, WA 98007**
425-747-7007 Office
425-747-7342 Fax
www.cranderegg.com