Capital City Dental Referral Form
79 Thurman Ave Columbus, OH 43136
Phone: (614)443-4625 • Fax: (614)449-6558
Email: Smiles@CapitalCityDental.com

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Preferred Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

REFERRING DENTIST / OFFICE

Referring Dentist: _____

Dental Office: _____

Office Phone: _____ Fax: _____

Email: _____

Address: _____

REASON FOR REFERRAL

Laser Fernectomy (including Tongue Tie release)
TMD pain Laser
Lip Lase
Smooth Lase
Night Lase
Cold sore Laser
Other: _____
Primary Concern / Reason for Referral:

_____

_____

RECORDS PROVIDED

X-Rays
Treatment History
Other: _____