DR. EMILY BATSON

DENTISTRY & PROSTHODONTICS

PATIENT REFERRAL

Name of Patient ______________________________

Patient Phone ______________________ **D.O.B.** ______________

Reason for Referral ______________________________

____

Would you like us to contact the patient? Yes ______ No ______

Radiographs?

Enclosed ________ Given to patient ________ Emailed ________

Would you like Dr. Batson to call you regarding your patient?

Yes ______ No ______

Name of Referring Doctor ______________________________

Doctor's Signature ______________________________

Date ______________

1580 E. Cheyenne Mtn. Blvd. Ste. 140
Colorado Springs, CO 80906

Phone 719.576.4247 | **Fax** 719.576.3070
BatsonDentistry.com