MAISON DENTAL

REFERRAL FORM

"Thank you for your referral. We are dedicated to fostering strong collaborative relationships and are committed to exclusively treating the cases that are referred to us. Your patients are in expert hands with us"

Patient Details:

Patient's Full Name: _____

IC Number: _____

Contact Number: _____ Email Address: _____

Medical History / Allergies:

_____

Treatment Needed:

_____

Referring Dentist Details:

Dentist's Name: _____

Dentist's Contact Number: _____

Dental Clinic Name & Address / Clinic Stamp:

Date of Referral: _____

Referral Details:

Referring to:

☐ Dr. Tan Hong Jin (Specialist Periodontist)

☐ Dr. Goh Sim Ying (Specialist Orthodontist)

☐ Dr. Tengku Maryam (Specialist Paediatric Dentist)

Reasons for Referral:
Please specify the site/tooth/area of concerns

Radiograph provided?

☐ Yes (Please indicate type of radiograph and date taken) _____

☐ No