



Hygienist Referral

DENTIST COMPLETE

Patient full names _____

Date of birth _____

Address _____

Patient reference _____

Referring dentist _____

Practice stamp

I confirm that the above patient is registered at this practice and that the last dental examination was done on ____ / ____ /20____.

The dental examination intervals are set for every _____ months.

Please provide the following treatment

Signed by dentist

Date

PATIENT COMPLETE

I agree to pay the fee of £55.00 per 30 minutes for my hygienist visit. I also agree to the terms and conditions of IGDP Limited regarding appointment attendance. No other treatment will be provided without a written referral from the dentist you are registered with.

Signed by patient

Date