All Pets Dental Care & Oral Surgery
570-839-1922
3180 Rte 940
Mt. Pocono, PA 18344

To be completed by referring doctor only

Dental Patient Referral Form

Client Name_____
Address_____
_____.
Telephone_____

Patient Name_____
Species_____ Breed_____
Age_____ Gender_____

Chief Complaint and Duration_____
_____.
Any Prior Treatment_____
_____.
Current Medication _____
_____.
Any concurrent medical conditions _____
_____.
Lab Results Included:
CBC Chemistry Profile Urinalysis
Radiographs Other_____.

Referring Doctor:
Name_____
Practice Name_____
Address_____
_____
Telephone_____ Fax_____
Email_____

Requesting a follow up telephone call post treatment. Y/N

Interested in learning about any future continuing education on veterinary dentistry. Y/N

How did you learn about our dental practice? _____
Additional information/comments: