PRINCETON PARK DENTAL ASSOCIATES, P.A.
DOCTOR REFERRAL FORM

DATA PROTECTION ACT OF 1998

The data collected in this form will only be used for the purpose of assessment and treatment of your condition within the dental practice and will only be disclosed to medical or dental professionals concerned with your particular care should outside referral be necessary. By completing this form you consent to us contacting your doctor, dentist, or referring you as required to fulfill this aim. This form will then be included in your medical history notes held at the dental practice.

Who is your current primary medical doctor?

Doctor Name: ______________________________

Doctor Address: ______________________________

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Telephone: ______________________________

Who is your current dentist?

Dentist Name: ______________________________

Dentist Address: ______________________________

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Telephone: ______________________________

Who is the referring doctor?

Doctor Name: ______________________________

Doctor Address: ______________________________

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Telephone: ______________________________

Who is your current cardiologist?

Doctor Name: ______________________________

Doctor Address: ______________________________

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Telephone: ______________________________