

11 George Street, Huntingdon, Cambs PE29 3BD
 Tel: 01480 453003 Fax: 01480 454352
 E-Mail: Info@wensleydaledental.co.uk
 Visit: www.wensleydale dental.co.uk

FACIAL AESTHETICS REFERRAL FORM

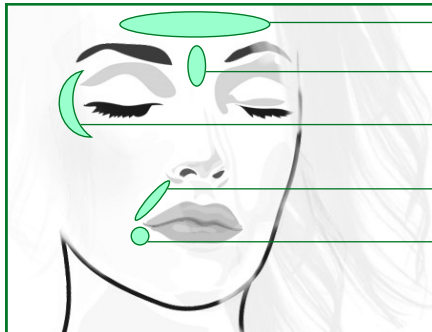
Patient Information

Name:	DOB:
Gender:	Tel Number:
Mobile:	E-Mail:
Address:	
Postcode:	
Relevant MH:	

Reason for Referral

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Area's Requiring Treatment



- Area 1 - Forehead lines (& frown Lines) -
- Area 2 - Frown lines (above Nose) -
- Area 3 - Crows feet (lines around the eyes) -
- Area 4 - Naso-labial folds (smile lines) -
- Area 5 - Oral Commisures (corner of the mouth) -

Referring Dentist

I confirm I have discussed the above treatment requirements with the patient and they have consented for their details to be sent and be treated by Mr Ubaid Khattak, Dental Surgeon at Wensleydale Dental Practice. The patient has been informed they will be seen and treated on a Private basis, independent from the NHS. All patients will initial be seen for a free consultation, whereupon treatment options will be discussed.

Signed:	Date:
Print name in capitals:	
Practice Name:	
Address:	
Postcode:	
Tel Number:	
E-mail:	