Implant Request Form

PRIORY DENTAL CARE

Patient Details

Title: First Name: Surname:

Address:

Postcode:

Date of Birth: Email:

Telephone: Mobile:

Referring Dentist Details

Dentist name: GDC No:

Practice Address:

Postcode: Telephone:

Email:

Reason for referral:

☐ Single Implant
☐ Multiple Implants
☐ Implant Retained Bridge
☐ Implant Retained Denture
☐ All-on-four concept

Please indicate tooth / teeth

	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
R		L
	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Radiograph(s) attached: ☐ Periapical ☐ Bitewing ☐ OPG ☐ No Radiographs

Initial Consultation Fee £50 (*as at 01/01/2026)*
A full written treatment plan will be provided to the patient following the initial consultation.

☐ I confirm that treatment options have been discussed with the patient. I confirm that the patient has consented to this referral and understands the reasons for it.

Referring Dentist Signature: Date:

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