Oral Surgery 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 / Treatment required:

- ☐ Apicectomy
- ☐ Coronectomy
- ☐ Impacted Tooth
- ☐ Complex Extraction
- ☐ Expose and Bond Canines
- ☐ Assessment / Removal of Cysts

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 given consent for this referral and understands the reasons for it.

Referring Dentist Signature: Date: