PATIENT REFERRAL

Aer Dental Studio
Dr. Michael Martins
1215 Smokey Park Hwy
Candler, NC 28715
828-665-7000
hello@aerdental.com

PATIENT INFORMATION

Full Name		Phone Number	
Date of Birth		Email Address	
Age		Home Address	

REFERRING DOCTOR INFORMATION

Referring Dentist/Doctor	
Referring Office	

Patient and doctor concerns to be addressed

REASON FOR REFERRAL

- ☐ Full Arch Dental Implants/AOX - please circle-> (upper only, lower only, both upper and lower)
- ☐ Dental Implants
- ☐ Cosmetic Dentistry / Smile makeover
- ☐ Nightlase (snore reduction laser treatment)
- ☐ Restorative Dentistry
- ☐ TMD / Jaw pain evaluation
- ☐ Sedation Dentistry
- ☐ Comprehensive Dental Care
- ☐ Other

Our referral policy:

By accepting this referral and attending the consult, I, the patinet understands and agree that I cannot be a patient of Dr. Martins' at Aer Dental Studio for any other dental care other than what was referred by my dentist for 2 years following the consult.

Patient Signature: _____ Date: _____

Please email the referral to our office: hello@aerdental.com