Florida Animal Dentistry
& ORAL SURGERY CENTER

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# Patient Referral Form

Date: ___ /___ /___

## *Client Information*

First and Last Name: _____
Alternate Contact (if needed): _____
Address: _____City, State & Zip_____
Email (For Medical Record/Reminders): _____
Primary Phone: (___) _____ Text Enabled? _____ ❒ Home ❒ Mobile ❒ Work ❒ Fax
Secondary Phone: (___) _____ Text Enabled? _____ ❒ Home ❒ Mobile ❒ Work ❒ Fax

## *Patient Information*

Name of Pet: _____ Species: Canine ❒ Feline ❒
Breed: _____ Color: _____
Age/DOB: _____ Sex: ❒ Male ❒ Neutered ❒ Female ❒ Spayed
Name of Family Veterinarian: _____
Name of Hospital: _____
Reason for Visit: _____
_____
List of Major Medical Problems: _____
_____
List all medications/Doses/Frequencies: _____
_____
Is your pet allergic to any medications? _____
History of Dental or anesthetic related problems/treatments: _____
_____
Date of Last professional dental cleaning: _____ Any Extractions? _____
Do you perform Home Dental Care such as brushing? _____
Current Diet: _____

Toys or treats that may have been provided: Please Circle

- Pig ears / Cow hooves / Antlers / Tennis balls / Sticks / Nylon bones / Rawhides / Frisbees /
- Ice cubes / Rocks / Rope toys / Bones / Cages / Other _____

Dental related signs you may have noticed: Please Circle

- Fractured or Broken Teeth / Discolored Teeth / Bad breath / Scratching at the Face / Persistent or
- Recurrent Facial Swelling / Reluctance to Chew Hard Toys or Food / Drooling or Dropping Food /
- Retained Baby Teeth / Loose Teeth / Growths on the Tongue, Lips or Gums / Bleeding Gums / Other _____