



LORI TREMBATH, D.D.S. P.C.  
FAMILY DENTISTRY

**Enter your information**

Email address: \_\_\_\_\_

Practice name: \_\_\_\_\_

**Patient details:**

Patient Name: \_\_\_\_\_

Patient Contact Number: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Please note specific patient needs for referral, area of concern and teeth involved in needed treatment:

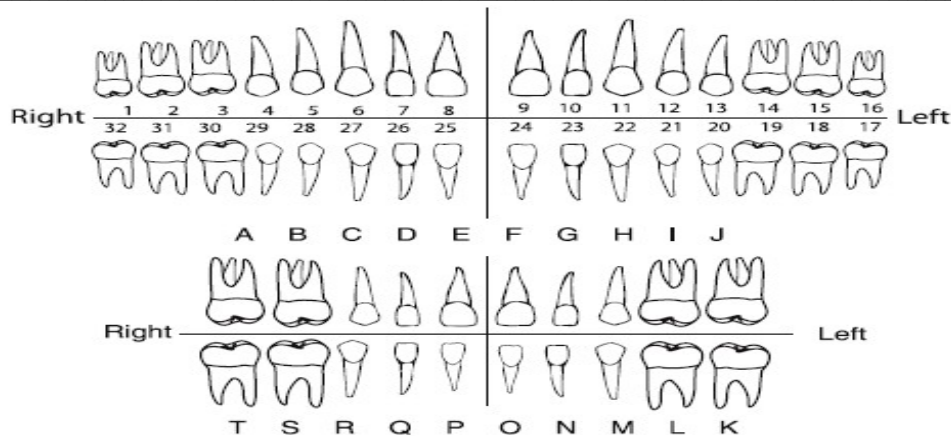
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Please send all documents; radiographs, perio-charting and/or chart notes that pertain to needed treatment, including dates. Thank you.