

Brief Medical and Dental history and endodontic procedure requested (please mention any current medication and or medical therapy.)

PCT charge collected (£)

Provider Use Only	
Date of first appointment	
Dates of treatment	
Returned (inappropriate referral)	
Referred to hospital	

Please complete this form and send back to:

**WATERSIDE DENTAL HEALTH
1 RALEIGH HOUSE
ADMIRALS WAY
LONDON
E14 9SN**