



**BLUE HILL**  
PENINSULA DENTAL

**Dr. Michael Gillins, D.M.D., FACP, DABP**  
**Prosthodontist**  
**120 South Street**  
**Blue Hill, Maine 04614**  
**207-374-5398**

**DENTAL REFERRAL FORM**

Referring Doctor: \_\_\_\_\_  
Referring Doctor's Telephone Number: (    ) \_\_\_\_\_-\_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Telephone number: (    ) \_\_\_\_/\_\_\_\_  
Email Address: \_\_\_\_\_  
Dental Insurance: (    ) Yes    (    ) No

**\*\*PLEASE CIRCLE:    EVALUATE    EVALUATE AND TREAT**

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last Panoramic X-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of last Full Mouth X-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*PLEASE FORWARD MOST CURRENT XRAY WITH THIS REFERRAL FORM\*\***

**PLEASE EMAIL REFERRAL FORM TO:**

**[Frontdesk@bluehilldentistry.com](mailto:Frontdesk@bluehilldentistry.com)**

**[Appointments will not be scheduled until all necessary information is received.](#)**