

PROSTHODONTIC REFERRAL – Fax referral to 416-586-4745

REFERRAL INFORMATION

Referral Date: _____
YYYY / MM / DD

Referral Name: _____

Referral Address (full address required)

Tel #

Fax :

PATIENT INFORMATION

Patient's Name: _____

Date of Birth: (YYYY / MM / DD)

Gender: _____

Address: _____

Postal Code: _____

Please check off preferred contact

Tel:(Home)

(Work)

(Cell)

PLEASE COMPLETE THE FOLLOWING INFORMATION

Urgency of care: Emergency care Urgent Routine

Dental X-rays: NO X-rays - Please take x-rays Sent with Patient Mailed Ceph Radiograph CBCT

Digital xrays (Printed NOT accepted) Mailed/Pt to bring

Reason for Referral:

Prosthodontic Consultation

Cosmetic Consultation & Treatment

All-On-Four Planning & Restoration

Implant Pre-Surgical Planning

Full Mouth Rehabilitation

Additional Information:

Relevant Dental / Medical History:

Current Medications:

Please:

Fax this referral form to **416-586-4745** Call the office for email information to send digital radiographs

Appointment Date & Time: _____

Cancellation Policy: This appointment time is reserved for your patient. If unable to attend, our office must be notified at least 3 working days in advance to avoid cancellation charges.