Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Department of Dentistry
600 University Ave. Suite #412
Toronto, Ontario M5G 1X5
T- 416-586-3234 F- 416-586-8632

APPOINTMENT INFORMATION-THIS FORM IS ONLY FOR THE CRITERIA LISTED BELOW

Date:_____ Who is your dentist or doctor?
YYYY / MM / DD

Dentist Address (full address please)	Tel #
	Fax :

PATIENT INFORMATION

Patient's Name:

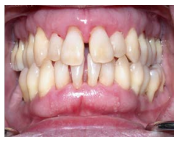
Date of Birth: (YYYY / MM / DD) Gender:

Address: Postal Code:

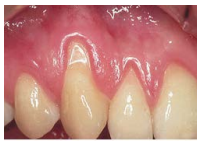
Please check off preferred contact
☐ Tel:(Home) ☐ (Work) ☐ (Cell)

PLEASE COMPLETE THIS INFORMATION FOR CRITERIA

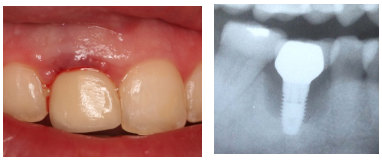
Do you have any of these problems?



☐
Gum Disease not improving despite treatment?



☐
Gum recession and black spaces between gums and teeth?'



☐
Dental implant problems?

Reason for Appointment:

☐ Dental Implant Related Problems (Gum and/or Bone)

Specific Area_____Generalized _____

☐ Gingival Recession/Attrition and Loss of gum tissue between teeth

☐ Gum disease unresponsive to treatment (loose teeth, recurrent gum abscess and/or continuous loss of bone)

Chief concern: ☐ Esthetics ☐ Tooth loss ☐ Discomfort ☐ Tooth Mobility

☐ If Other, please specify: _____

Relevant Dental/Medical History:

Additional Comments:

Please: Fax this referral form to **416-586-8632.**

Appointment Date & Time: _____

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