**Ginny Eidinger, D.M.D., F R.C.D. (C)**
**Oral and Maxillofacial Surgeon**
**132 Sheppard Avenue West, Suite #102**
**Toronto, Ontario M2N 1M5**
**(416) 538 2002**

**PATIENT INFORMATION**

**First Name** _____
**Last Name** _____
**Date of Birth** _____ **Gender** _____
**Patient Email** _____
**Phone #** _____

**REFERRING DOCTOR INFORMATION**

**Referred by** _____
**Date of Referral** _____
**Phone Number** _____
**Email Address** _____

**REASON FOR REFERRAL**

**Extraction** _____
**Implants** _____
**Implant preferred:** ☐ **Nobel Biocare** ☐ **ZimVie**
**Bone Grafting** _____
**Sinus Lift** _____
**Frenectomy** _____
**Pathology/Biopsy** _____
**Orthodontic Exposure/Bonding** _____
**Other** _____

**RADIOGRAPHS**

**Requested** ☐
**Given to Patient** ☐
**Being Emailed/Mailed** ☐

**APPOINTMENT INFORMATION**

**Call Patient** ☐
**Patient will Call Us** ☐
**Appointment Date and Time** _____

**CIRCLE TEETH INVOLVED**

**PERMANENT DENTITION**

| RIGHT | | | | | | | | LEFT | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

**PRIMARY DENTITION**

| RIGHT | | | | | | | | LEFT | |
|---|---|---|---|---|---|---|---|---|---|
| E | D | C | B | A | A | B | C | D | E |
| E | D | C | B | A | A | B | C | D | E |

**COMMENTS OR INSTRUCTIONS:** _____

TO OUR PATIENTS:
Notify us 2 days before your appointment to avoid a missed appointment cancellation fee.
Bring the following items to your appointment:

- your referral slip
- x-rays if given to you by your dentist
- government issued ID
- a list of your medications
- your dental insurance information