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(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