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

Dr. Michael Goldberg
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Tel: 416-586-3234 Fax: 416-586-8632

CLEAR FORM PRINT FORM

PERIODONTIC REFERRAL

REFERRAL INFORMATION

Referral Date:_____ Referral Name:
YYYY / MM / DD

Referral Address (full address required) | Tel #
Fax :

PATIENT INFORMATION

Patient's Name:

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

Address: Postal Code: Email:

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

PLEASE COMLETE THE FOLLOWING INFORMATION

Urgency of care: ☐ Emergency care ☐ Urgent ☐ Routine

Dental X-rays: ☐ NO X-rays - Please take x-rays ☐ Sent with Patient ☐ Mailed

☐ Recent full mouth x-rays survey (Date_____) ☐ Partial x-ray survey (# of films)_____ (Date_____)

☐ Panoramic film

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

Reason for Referral:

☐ Complete Periodontal Examination ☐ Specific area _____
☐ Pathology/Lesions ☐ Mucogingival evaluation/Gingival Recession
☐ Crown-Lengthening Consultation ☐ Periodontal Abscess Bone Loss
☐ Recent Scaling/Root planning (_____ months ago) Is on a recall every _____months

Patients's chief concern: ☐ Esthetics ☐ Tooth loss ☐ Discomfort ☐ Tooth Mobility ☐ Other

Relevant Dental/Medical History:

Additional Comments:

Please: Fax this referral form to **416-586-8632** Call the office for email information to transfer 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.