

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 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

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.