

## Patient Information

Prefix \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_ DOB (MM/DD/YYYY) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone (Home) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Email Address \_\_\_\_\_

## Administrative Information

### Periodontics:

- First Available**
- Cameron Jones
- Gordon Schwartz
- Eugenie MacKay
- Karen Fung
- Alison McGuire
- Isabelle Quenneville
- Janelle Hamilton

### Oral Surgery:

- First Available**
- Tara Valiquette
- Ian Buckley
- Amin Alibhai

### Other:

- Daniel Turgeon  
Oral Radiology
- Sherif Elsaraj  
Sleep Apnea & TMD

Referring Dentist \_\_\_\_\_ Ref. Office Name \_\_\_\_\_ Ref. Office Phone \_\_\_\_\_

Ref. Office Email Address \_\_\_\_\_ Date Referred (MM/DD/YYYY) \_\_\_\_\_

## Treatment Information

- Specific Consultation     Comprehensive Consultation

Patient has had recent radiographs: \_\_\_\_\_ Reason for referral: \_\_\_\_\_

Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, please send via mail or email \_\_\_\_\_

### Please mark teeth or area to be treated

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
			55	54	53	52	51	61	62	63	64	65			
			85	84	83	82	81	71	72	73	74	75			
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Additional Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Thank you for your referral!