



- 291 King Street East, Oshawa, 905-728-5793
- 4800 Leslie St. #111, North York, 416-498-8484
- 460 Main St. E., #301, Hamilton, 905-526-6078
- 5293 Highway 7, #208, Markham, 905-472-5522

- 312 Dundas Street West, Whitby, 905-668-6301
- 118 King Avenue West, Newcastle, 905-987-4466
- 230 Sandalwood P kwy E., Brampton, 905-846-4004
- 830 Rowntree Dairy Rd, Woodbridge, 905-856-6198

Patient Name _____

Telephone # _____

Referred by Dr. _____

Date of Appointment _____

Time of Appointment _____

Patient is referred for:

- | | |
|---|---|
| <input type="checkbox"/> General Perio Treatment <ul style="list-style-type: none"> <input type="checkbox"/> Is a new patient <input type="checkbox"/> Is on recall every ____ months <input type="checkbox"/> Has had scaling: Date _____ <input type="checkbox"/> Has had Perio surgery: Date _____ <input type="checkbox"/> Has had caries control: <ul style="list-style-type: none"> <input type="checkbox"/> In progress <input type="checkbox"/> Completed <input type="checkbox"/> Has been advised of the possibility of extraction of the following teeth: _____ | <input type="checkbox"/> Crown Lengthening _____
<input type="checkbox"/> Gingival Recession _____
<input type="checkbox"/> Extraction(s) _____
<input type="checkbox"/> Dental Implant(s) _____
<input type="checkbox"/> Emergency Treatment _____
<input type="checkbox"/> Other _____ |
|---|---|

Available radiographs:

- Full Mouth Series
 Bitewings
 Panoramic
 Periapicals
 CT Scan
 Are enclosed
 E-mailed
 Mailed
 Patient will bring
 Please take

Comments/Considerations _____

Please call me

Dentist Signature _____ Date _____