DENTISTRY ON AIRPORT

391 Airport Road, North Bay, Ontario P1B 8W8
705-472-1771
www.dentistryonairport.ca
treatmentcoordinator.doa@gmail.com

Referral Form

FROM:

WE ARE REFERRING:

Patient: **Parent/Guardian:**

Birthdate: **Telephone:**

Address:

Dental Insurance: ☐ Yes ☐ No

Policy Holder's name (if different from referred patient):

Date of Birth: **Insurance Company:**

Policy#: **Certificate#:**

REASON FOR REFERRAL:

☐ **CONSULTATION** Reason/ specific remark:

☐ **TREATMENT** (as requested): (Please provide Dentist with appropriate details of problem; i.e. urgency, areas of concern, using F.D.I. tooth numbering system.)

☐ **RELEVANT HISTORY:** (Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.)

SERVICE REQUESTED:

☐ Restoration ☐ Tooth Extraction ☐ Wisdom Teeth Extraction
☐ Crown ☐ Dental Implant

SEDATION REQUIRED:

☐ General Anaesthesia ☐ IV Sedation

☐ Please call the patient / ☐ Patient will call ☐ An appointment has been made

☐ Radiographs are enclosed ☐ Other records are available

Written report with all the radiographs taken for diagnosis and treatment will be sent to your clinic post treatment via email.

Note for the referring clinic : All the referral patients will be paying upfront for the treatment except some insurance exception for certain treatment.

Signed: **Date:**