THUNDER BAY
PROSTHODONTICS

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Referral Form

Patient Information

Patient Name:

Address:

Phone:	E-mail:
Date of Birth:	Insurance:

Referred by Dr.:

Phone:	Fax:
E-mail:	Preferred method of correspondence:
Date of referral:	

Reason for referral

☐ Full mouth rehabilitation

☐ Implant treatment

☐ Complete or partial dentures

☐ Localized treatment of:

Radiographs/CBCT images:

☐ Sent with patient ☐ Mailed ☐ E-mailed ☐ To be taken

- Please contact us by phone or email to schedule an appointment
- A consultation appointment is required before starting treatment. At this time medical and dental history will be reviewed and necessary diagnostic procedures will be completed in order to create a treatment plan.
- Appointments must be confirmed **2 days prior**, otherwise we reserve the right to cancel the appointment.

Appointment date and time: