



Certified Specialist
BSc, DDS, Dip Periodontics, FBCCD
Periodontics, Implant Surgery
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PH 250-851-2570, FAX 250-851-9929

PERIODONTAL REFERRAL FORM

Date _____

Referring Dentist: _____
Phone _____

Patient Name: _____
Patient Address: _____
City, Postal Code: _____
Home Phone: _____
Bus/Cell/Pager Phone: _____

Patient Referred For:

- a) full consult _____
- b) specific consult(area) _____
 - i) graft with or without root coverage _____
 - ii) crown lengthening _____
 - iii) biopsy _____
 - iv) ridge augmentation _____
- c) implants, which regions? _____

Dental Insurance Information:

1) Plan #1

Group or Policy # _____
Certificate or ID # _____
Company Name: _____
Name Policy Holder: _____
Birthdate: _____
Name Employer: _____
Position with Employer: _____

2) Plan #2

Group or Policy #: _____
Certificate or ID# _____
Company Name: _____
Name of Policy Holder: _____
Birthdate: _____
Name of Employer _____
Position with Employer _____

Do you feel this patient would benefit from treatment done with iv sedation during surgery? Yes No

Medical Hx (ie allergies) _____

Social Hx (ie. smoking) _____

Restorative Plan _____

Radiographs Enclosed Yes No

Type of Films _____

Date of Films _____

Additional Comments:

Patient has made an appointment with you on _____

Patient will call for an appointment

Please call patient for an appointment. Best Time and Phone # _____

The patient prefers to be addressed as _____

Address & Directions: