LONDON NORTH DENTAL CENTRE

Tel: 226-212-8088 / Fax: 226-212-8089 Email: sandhugumsrus@gmail.com
850 Medway Park Dr, London ON, N6G 5C6, Canada

Periodontics

REFERRAL INFORMATION

PLEASE NOTE: *ALL requested information in this form must be completed to avoid any delays in booking consultation appointment.*

- This is a consultation appointment only. **Duration-Approximately 1.5 Hours**
- Cancellation notice of **3 business days** is required for any appointment to avoid a **cancellation charge of $250.00.**
- **Patient is responsible for providing an interpreter on the day of the appointment *if needed***

Date: ______________________

1. SOURCE OF REFERRAL

Referring ☐DDS ☐MD: ____________________, ____________________
Last Name **First Name**

Address: ____________________________________ City ____________________ PC: ____________

Phone #: _________________Fax #: __________________ Email: _________________________________

2. PATIENT INFORMATION: ☐ New Patient ☐ Previous Patient Patient's

Name: ________________________, _______________________ **Gender** _______________
Last Name **First Name**

DOB: _____/ _____/_____ Medical Concern: ______________________________
dd **mm** **yy**

Address: ____________________________________ City ____________________ PC: ____________

Home Phone #: __________________ CP: __________________ e-mail : ______________________

3. INSURANCE TYPE: (Please check all appropriate)

☐ No Insurance ☐ Insurance Exp. Date: ______________________

Insurance Company __________________________

4. REASON FOR REFERRAL: (Check all that applies)

General Periodontal Evaluation Pre-Orthodontic Evaluation Mucogingival Surgery Root Coverage Gingival Augmentation Ridge Augmentation Treatment of Gummy Smile Crown Lengthening Pocket Reduction Surgery Enhanced Maintenance Therapy Treatment of Peri-implantitis ☐

OTHER:

Dentist Main Concern. please specify in detail.

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5. Please be as detailed as possible. This allows us to establish a history and idea of how to proceed with treatment.

How was the patient's previous experience/cooperation within your office?

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☐ Have you completed any procedures on this patient? ☐No ☐Yes **(Please specify treatment rendered and date)**

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Recall/NPE (last Date): ______________________________

Radiographs (most recent)

☐ Yes Date Taken: _______________ ☐ e-mailed or mailed ☐ send with patient

☐ No

Please email all appropriate radiographs with patient's name and date taken in the subject line to sandhugumsrus@gmail.com

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"Office use only"

Consult

☐ Duration: approximately 2Hrs

Payment Policy:

☐Payment Due Day of Visit ☐ Visa/Mc/Debit/Cash ☐ $_______________ + x-rays (if needed)

Cancelation Policy:

☐ 3 Business Days' Notice Requires (if Less-rebooking fee of $250.00)

Explained/Booked with: ______________________________

Appt Date: ________________________ **Booked By:** ________________________