SUNCOAST DENTAL

5-397 Bayfield Road, Goderich, ON N7A 4E9
Tel: (226)-227-6453
Email: info@suncoastdental.ca

Dentist Referral Form

REFERRING DENTIST DETAILS:

Dentist Name: _____

Practice Name: _____

Practice Address: _____

City: _____ Postal Code: _____

Telephone: _____ Email: _____

PATIENT DETAILS:

Full Name: _____ D.O.B: _____

Address: _____

City: _____ Postal Code: _____

Telephone: (Home) _____ (Mobile) _____

Email: _____

Insurance Information:

SubscriberFull Name: _____ D.O.B: _____

Insurance Company: _____

Policy: _____ ID No.: _____

REASON FOR REFERRAL:

□	Intraoral Scanning	□	Dental Implant □ Placement only □ Placement + Scan* □ Placement + Final Restoration
□	Surgical Exodontia		
□	Biopsy	□	Implant Retained Dentures
□	Sedation - □ Nitrous □ Oral □ IV Sedation □ General Anesthesia		
□	Pediatric Specialist	□	Other:

Treatment Details: _____

_____

_____

Patient Medical History: _____

_____

_____

Patient Radiographs Included:

□ Bitewing □ Periapical □ Panoramic □ CBCT □ Intraoral Photo □ No Record

Date: _____ Signature: _____

* Implant Placement & Scan we will send to a Lab of your choice and have them invoice your office directly for the final prosthetic if you wish to restore.