7 Riverside Drive
Welland, Ontario
L3C5C6
(T) 905-735-7571 (E) info@wellanddentalcentre.ca

PERIODONTIST REFERRAL FORM

Referring Doctor:_____ **Date:**_____

Address: _____ **Phone:**_____

Patient Information:

Name: _____ **DOB(DD/MM/YYYY):** _____

Address: _____

Phone number: _____ **Email address:** _____

Reason for Referral: ☐ **Consultation only** ☐ **Consultation & Treatment**

☐ **Implant Consultation** ☐ **Specific Problem** ☐ **Tissue grafting** ☐ **Other**

Tooth/ Teeth numbers:_____

Notes:_____

_____

Insurance information

Primary:

Carrier _____ ID _____ Group ID _____

Subscriber information if different from patient information

NAME _____ DOB _____

Secondary:

Carrier _____ ID _____ Group ID _____

Secondary subscriber: NAME _____ DOB _____

Appointment Details:

☐ We have scheduled the following appointment:
Appointment Date:_____Time:_____

☐ Patient will call to schedule appointment

☐ Please contact patient to schedule appointment

Please send any x-rays, intraoral photos, and the patients most recent perio chart.