FIRST IMPRESSIONS DENTURE CLINIC

Referral Sheet

Patient Name: _____

Address: _____

Phone Number: _____

Email: _____

Date of Birth: _____/_____/_____

Alberta Health Care Number: _____

Referring Doctor

Referring Doctor/Office name: _____

Office Email: _____

Office Phone Number: _____

Treatment Required

- ☐ Complete Dentures(s)
- ☐ Immediate Denture(s)
- ☐ Partial Denture(s): Cast or Acrylic
- ☐ Relines
- ☐ Repairs
- ☐ Implant Supported Dentures

Insurance Information

Insurance Company: _____

Insurance Carrier/Subscriber: ☐ Patient ☐ Spouse

Spouse's Date of Birth: _____/_____/_____

Policy number: _____ Division number: _____ Group number: _____

Additional Comments

_____

_____

780.487.6686 | 19, 9977 178 ST | Edmonton, AB T5T6J6 | info@firstimpressionsdenture.ca