Pediatric Dentistry and Orthodontics
Tel: (519) 679-6822 / Fax #: (519) 679-3450 Email: referrals@pediatricdentistry.ca
577 Oxford Street London, ON N5Y 3H9

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 2 Hours**
- Cancellation notice of **3 business days** is required for any appointment to avoid a **cancellation charge of $250.00.**
- **Parent/Guardian is responsible for providing an interpreter on the day of the appointment.**

Date: ______________________

1. SOURCE OF REFERRAL ☐ Other (specify): ____

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

Address: ___________________________________ City ____________________ PC: ____________

Phone #: ________________Fax #: __________________ Email: ________________________________

2. PATIENT INFORMATION: ☐New Patient ☐ Previous Patient

Any siblings referred to our office before? Name: __________________ ☐ Yes ☐ No

Patient's Name: _______________________, ______________________ ☐ **M** ☐ **F**
Last Name **First Name**

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

Address: ___________________________________ City ____________________ PC: ____________

Home Phone #: ______________________ CP: _____________________ Other: ___________________

Parent/Guardian: __________________________, __________________________
Last Name **First**

Name Email Address: ___________________________________

3. CUSTODY ISSUES: ☐ No ☐Yes (**bring Proof of Custody on the day of consultation appt**)

Legal Guardian: ____________________, ______________________
Last Name **First Name**

Home Phone #: ______________________ CP: _____________________ Other: ___________________

4. INSURANCE TYPE: (Please circle all appropriate)

☐No Insurance ☐Private ☐HSO #___________________ Exp: ____________

☐CAS-CITY: ________________________ → ☐ GSC ☐Other: ______________________

Signing Authority: _________________, ____________________(**MUST BE PRESENT ON THE APPT DAY)**
Last Name **First Name**

Phone #: _________________________________

5. REASON FOR REFERRAL:

☐Caries/Age ☐Beh ☐Pain ☐Scope of treatment ☐Restorative Needs

☐Orthodontics ☐ 1st Dental Visit ☐Other: ____________________

Dentist Main Concern. please specify in detail.

____

____

☐ If Trauma-Date: ____________

Description of the Incident:

____

____

6. 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?

____

____

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

____

____

Recall/NPE (last Date): ____________

Radiographs (most recent) ☐Yes Date Taken: ____________ ☐ No

☐e-mailed ☐with parent ☐mail

_____ #BW _____ #↑ / ↓OCC _____ #PA _____ PAN _____Other

Please email all appropriate radiographs with patient's name and date taken in the subject line to referrals@pediatricdentistry.ca

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"For Pediatric Dentistry and Orthodontics use only"

Consult

☐Duration: approximately 2Hrs

☐Parent/Guardian must be present on the day of the consultation day

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:** ____________