YORKVILLE VILLAGE DENTISTRY

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PATIENT REFERRAL FORM

Introducing: _____ **Date:** _____

Contact:
Home _____
Mobile _____
E-mail _____
DOB (DD/MM/YYYY) _____

Referred To:
- ☐ Dr. Joseph Fava (Prosthodontist)
- ☐ Dr. Vanessa Mendes (Periodontist)
- ☐ Dr. Anna De Filippo (Periodontist)
- ☐ Dr. Leslie Laing (Prosthodontist)

Consultation Regarding:

- ☐ Full mouth rehabilitation
- ☐ TMD/Pain
- ☐ Removable Prosthodontics (Dentures)
- ☐ Fixed Prosthodontics (Crown and bridge)
- ☐ Complete Periodontal Assessment
- ☐ Specific Periodontal Assessment
- ☐ Mucogingival / Soft Tissue Graft
- ☐ Implant Assessment
- ☐ Bone Grafting / Sinus Lift
- ☐ Extraction

Radiographs:

- ☐ Recent radiographs / FMX (Date) _____
- ☐ Panoramic (Date) _____
- ☐ CT scan (Date) _____
- ☐ Please take
- ☐ Recent scaling and root planning (Date) _____

Significant Medical & Dental History: _____
_____
_____

Patients Chief Concern: _____
_____
_____

Comments: _____
_____
_____

Referred by Dr.: _____ **Dr's Signature**: _____