CORE DENTAL SPECIALTY GROUP

Referral Form

Referring to: _____

☐ **Dr. Kirk Sutton**
DMD, MSc, FRCD(C), Cert Pros

☐ **Dr. Breanne Joslin**
DMD,MSc, FRSC(C), Dip Perio

☐ **Dr. Rashi Chaturvedi**
BDS,MDS,MSc.,Dip Perio,FRCD(C), DABP

REFERRING DOCTOR

Referring Dentist: _____

Phone: _____ Date: _____

WE ARE REFERRING

Patient's Name: _____ Email: _____

Date of Birth: ____ / ____ / _____

Home Phone: _____ Cell Number: _____

INSURANCE INFORMATION

Insurance: ☐ YES ☐ NO ☐ DUAL

Policy Holder's Name: _____ D.O.B: _____

Insurance Provider: _____

Group #: _____ ID Certificate #: _____

REASON FOR REFERRAL:

☐ Implants:
- ☐ Surgical only, please return for prosthetics
- ☐ Prosthetics only
- ☐ Surgical and Prosthetics

☐ Grafting:
- ☐ Soft Tissue
- ☐ Hard Tissue

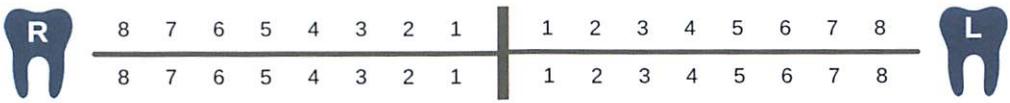
☐ Perio Assement: _____

☐ Surgical extraction: _____

☐ Comprehensive Restorative TX: _____

☐ Occlusal Concerns: _____

☐ TMD Concerns: _____



Comments: _____

#410A-20020 84 Ave
Langley, BC V2Y5K9
www.coredentalgroup.com

Phone: 604-881-1381
Fax: 604-881-10381
Email: info@coredentalgroup.com