smilesUnlimited
DENTAL CENTRE

TREATMENT REFERRAL

Patient's Name: ______________________________

Telephone: ______________________ Today's Date: ______________________

Referring Doctor Name & Telephone: ______________________________

Date of Appointment: ______________________

Please forward x-rays and dental insurance information.

☐ Please Call Patient ☐ Patient Will Call ☐ X-Ray Sent

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75

☐ Connective Tissue Graft
☐ Free Gingival Graft
☐ Implant Surgery Only
☐ Implant Surgery & Prosthetics
☐ Wisdom Teeth
☐ Full Mouth Rehabilitation
☐ Teeth-in-an-Hour™ (Guided Surgery)
☐ Bone Grafting
☐ All-on-4™
☐ Conscious Sedation

Doctor's Comments: ______________________________
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☐ BITES Institute member

Signature of Referring Doctor ______________________

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www.GoodbyeDentures.ca

Missed appointments are subject to a $50 fee (if cancelled with less than 48 hrs notice)