smilesUnlimited DENTAL CENTRE

REFERRAL FOR TREATMENT

Patient Name: _____

Telephone #: _____ Date of Referral: _____

Referring Doctor & Phone #: _____

Please check ☑ all that apply:

- ☐ Please call Patient
- ☐ Patient will call you
- ☐ X-ray imaging is sent by (*circle one*): Courier / E-mail / With the patient
- ☐ Dental insurance information is enclosed

TREATMENT requested:

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			

- ☐ Extractions
- ☐ IV Sedation
- ☐ Immediate Extraction & Immediate Provisionalization (temporary)
- ☐ Connective Tissue / Free Gingival Grafting
- ☐ Wisdom Teeth Extraction
- ☐ Bone Grafting / Augmentation / Ridge Preservation
- ☐ Sinus Lift (Lateral / Crestal)
- ☐ Implant Surgery (with / without Final Prosthodontic Restoration)
- ☐ Restorations / Hygiene under IV Sedation
- ☐ Full Arch/Mouth Rehabilitation
- ☐ Cone Beam CT Scan (single – maxilla / mandible or both arches)

Additional Comments: _____

_____

Signature of Referring DMD/DDS: _____

- ☐ Check if you are a BITES Institute member

Dr. Bernard Jin DMD
949 Como Lake Avenue, Coquitlam, BC V3J 3N2
SmilesUnlimited.ca

T: 604.939.6111
F: 1.866.390.8014
GoodbyeDentures.ca