BARRIE
Dental Specialists

IMPORTANT

Please print clearly so that we are able to provide quality care for your patient.
Please remind your patient that we are a **fee for service** Multidisciplinary Dental Specialty Practice.

REFERRING DOCTOR: (*Required Information)

*Doctor's Name: _____

*Office Phone Number: _____

*Email: _____

PATIENT INFORMATION: (*Required Information)

*Patients Name: _____

*D.O.B.: (Day)_____/(Month) _____/(Year) _____

Address: _____

*Tel: Home: (_____) _____Cell: (_____) _____Other: (_____) _____

Patient Email:_____

Dental Insurance Information (if applicable): (*Required Information)

Primary Insurance Company:

*Policy Holders Name: _____ *D.O.B.: (Day)____/(Month) _____/(Year) _____

*Insurance Company: _____ *Group Policy #: _____*ID/ Certificate #: _____

Secondary Insurance Company:

*Policy Holders Name: _____ *D.O.B.: (Day)____/(Month) _____/(Year) _____

*Insurance Company: _____ *Group Policy #: _____*ID/ Certificate #: _____

☐ Prosthodontic Consultation
☐ Periodontal Consultation
☐ Oral Pathology

AREA OF CONCERN:

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

REQUIRED: DETAILED REASONS FOR REFERRAL

_____

_____

_____

IF REFERRAL IS FOR IMPLANT PLACEMENT WILL YOU BE RESTORING IMPLANT AFTER FINAL INTEGRATION? ☐ **YES** ☐ **NO** Please restore at Barrie Dental Specialists

Radiography Information: Will you be sending radiographs? ☐ Yes ☐ No

☐ Bitewings ☐ Periapicals ☐ Panoramic ☐ CBCT ☐ Full Mouth Series

Please send with dates if available:

☐ Mailed ☐ Emailed ☐ Coming with patient ☐ Please Take

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