PATIENT REFERRAL FORM

BURLINGTON PROSTHODONTICS
CERTIFIED SPECIALISTS
IMPLANT, ESTHETIC, & RECONSTRUCTIVE DENTISTRY
425 Locust Street – Suite 200, Burlington, ON L7S 1T8

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○ Dr. Oliver Pin-Harry **PROSTHODONTIST**	○ Dr. Michael Yang **PROSTHODONTIST**	○ First Available

INTRODUCING: _____ DATE: _____

CONTACT: Home _____ Preferred Method of Contact:
Mobile _____ ○ Home ○ Work
Email _____ ○ Mobile ○ Email

DATE OF BIRTH: ___/___/_____ (MM/DD/YYYY)

APPOINTMENT:
- ○ Already scheduled. Date: _____ Time: _____
- ○ Please contact patient
- ○ Patient will contact your office

CONSULTATION REGARDING:

_____
_____
_____

SIGNIFICANT MEDICAL & DENTAL HISTORY:

_____
_____

RADIOGRAPHS:
- ○ Emailed (preferred)
- ○ Enclosed
- ○ Mailed
- ○ With Patient
- ○ None

REFERRED BY:

_____

SIGNATURE:

_____