AYLMER
Dental Care Centre

Referral Form

Patient Information

First and last name

Gender

☐ Male ☐ Female

Date of birth (DD/MM/YYYY)

Phone number

Email address

Street address

City

Province

Postal code

Alternate/emergency contact

Doctor Information

Referring office

Referring doctor

Phone number

Branch of dentistry (select all that apply)

☐ Sedation ☐ Implants ☐ Complicated Extractions ☐ Orthodontics

☐ Myofunctional Therapy ☐ Dentures ☐ Perio ☐ Aesthetics

Referral Information

Reason for referral

Area of concern

Insurance Information

Insurance ID

Policy number

Policyholder

Policyholder's date of birth (DD/MM/YYYY)

Insurance company

Secondary Insurance Information

Insurance ID

Policy number

Policyholder

Policyholder's date of birth (DD/MM/YYYY)

Insurance company

Other Information

Relevant medical history

Additional notes

Records

Please include any/all records (Radiographs, Pan, CBCT, Photographs, Health history, Medical list, Chart notes)