Cottonwood Dental Care

11939 240 Street, #240
Maple Ridge, BC V4R 1M7

REFERRING DOCTOR INFORMATION

Practice Name: _____ Referring Dentist: _____

Phone: _____ Fax: _____ Email: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth (DD/MM/YYYY): _____ Gender: ◯ Male ◯ Female

Email: _____ Phone: _____

REFERRAL DETAILS

◯ Dental Implant Assessment ◯ Surgical Placement Only

◯ Surgical Placement & Restoration ◯ Bone Grafting / Sinus Lift

◯ Other: _____

TOOTH/AREA OF CONCERN

Indicate tooth numbers or quadrants:

_____

RELEVANT MEDICAL HISTORY

◯ No significant findings ◯ Diabetes ◯ Cardiovascular Conditions

◯ Bleeding Disorders ◯ Smoking History

◯ Allergies: _____

◯ Medications: _____ ◯ Other: _____

RADIOGRAPHS PROVIDED

◯ Digital X-Rays Emailed ◯ Hard Copies with Patient

◯ CBCT Scan Provided ◯ No Radiographs Provided

ADDITIONAL NOTES

_____

_____

Thank you for your referral!
Our team at Cottonwood Dental Care (Apple Implant Centre) looks forward to providing your patient with exceptional care. We will keep you updated throughout the treatment process.

_____ _____

Referring Dentist Signature Date