REFERRAL FORM

Dr. Jacob Rifkind

Oral Maxillofacial Surgeon

100 Waterloo Rd, Timmins, ON P4N 4X5

Phone: 705-267-1020 Fax: 705-268-8350

Email: specialists@hollingerdental.ca

Date: _____

Patient: _____ DOB: _____

Male □ Female □

Full Address: _____

Home Phone: _____ Work: _____ Cell: _____

SERVICE REQUESTED:

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 E D C B A A B C D E

_____ _____

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 E D C B A A B C D E

□ Consult □ Extractions with: □ IV Sedation □ Local Anesthetic

REMARKS OR SPECIAL NEEDS:

_____

_____

_____

_____

Radiographs: Panorex within 1 year: Date: _____ □ Mailed □ Emailed

Dental Insurance: _____

Policy #: _____ Certificate ID#: _____

Policy Holder's Name: _____ DOB: _____

2nd Dental Insurance: _____

Policy #: _____ Certificate ID #: _____

Policy Holder's Name: _____ DOB: _____

REFERRING DENTIST: _____

DENTAL OFFICE NAME: _____