HOLLINGER DENTAL GROUP

PERIODONTIC REFERRAL FORM **DR. STEVE KOZOMARA**

100 Waterloo Rd. ▪ Timmins, ON P4N 4X5
Phone 705-267-1020 ▪ Fax 705-268-8350

PATIENT INFORMATION DATE:_____

PATIENTS'S NAME: _____ DOB: _____

TELEPHONE NUMBER: (H): _____ (M): _____

ADDRESS:_____

PATIENT EMAIL:_____ REFERRING DENTIST: _____

INSURANCE DETAILS

INSURANCE COMPANY: _____ INSURANCE HOLDER:_____

GROUP#:_____ CERTIFICATE#:_____ DOB:_____

2nd INSURANCE:_____ INSURANCE HOLDER:_____

GROUP#:_____ CERTIFICATE#:_____ DOB:_____

PERIODONTAL REFERRAL DETAILS:

☐ GENERALIZED EVALUATION: _____

☐ SPECIFIC EVALUATION: _____

☐ CROWN LENGTHENING: _____

☐ SOFT TISSUE GRAFT: _____

IMPLANT REFERRAL:

☐ IMPLANT LOCATION: _____

☐ BONE GRAFTING: _____

☐ SINUS LIFT: _____

OTHER:

☐ TMJ/FACIAL PAIN: _____

☐ ORAL PATHOLOGY / BIOPSY: _____

☐ PRE-ORTODONTIC: _____

☐ OTHER: _____

PATIENT BACKGROUND:

MEDICAL CONCERNS: ☐ Pre-medication ☐ Other: _____

_____

_____

ON RECALL EVERY: _____MONTHS

MOST RECENT SCALING ON: _____

COMMENTS:_____

_____

_____

_____

Please include current vertical x-rays and photos. (Especially of the area in question.)

E-mail: specialists@hollingerdental.ca