Oral Surgery Referral

Dr. Andy Wong, DDS, FRCD (C)
Dr. Ron Ho, DDS, FRCD (C)

Clarence Street DENTAL Group

Patient's Name: ______________________________

DOB: ______________________________

Phone #: ______________________________

Email Address: ______________________________

Referring Doctor: ______________________________

Clinic Phone #: ______________________________

Clinic Email: ______________________________

Tooth/Teeth to be treated:

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

55 54 53 52 51 61 62 63 64 65

85 84 83 82 81 71 72 73 74 75

48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

Note: ______________________________

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Type of treatment:

❑ Extraction ❑ Implant ❑ Cyst Removal & Biopsy ❑ TMJ

Sedation Needed? ❑ Yes ❑ No

X-rays to be emailed: ______________________________

***At Clarence Street Dental, we require payment at the time of service. We will submit to your insurance carrier on your behalf for your reimbursement. Your appointment can be paid by Visa, Mastercard or Debit. We regret to inform you that we do not accept ODSP or HSO as a form of payment.**