# Requisition for Dental Specialist

- Dr. Mark Pus, Orthodontist
- Dr. Ryan Margel, Endodontist
- Dr. Jacob Swiderski, Periodontist
- Dr. Andy Wong, Oral Surgeon
- Dr. Ron Ho, Oral Surgeon
- Mr. Carmelo Cino, Denturist

Clarence Street
DENTAL Group

Patient's Name ______________________ DOB: ______________________

Address: ______________________

Phone #: ______________________ Email Address: ______________________

Referring Doctor: ______________________ Clinic Phone #: ______________________

Clinic Fax #: ______________________ Clinic Email: ______________________

**What is your main concern?** ______________________

______________________

**Area of Concern:** ❑ Upper ❑ Lower ❑ Left ❑ Front ❑ Right

**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

**Type of Specialist Needed:**

❑ Orthodontist
❑ Endodontist (Root Canal Specialist)
❑ Periodontist ( Gum Specialist)
❑ CBCT Scan
❑ Oral Surgeon
❑ Denturist

Please sign below to have any recent x-rays and dental history forwarded to Clarence Street Dental for this consultation with our specialist. This can aid the specialist and possibly prevent new x-rays from being needed.

I hereby authorize Clarence Street Dental to obtain my dental xrays and records in regards my upcoming consultation.

Patient/Parent's Name: ______________________ Date: ______________________

Patient/Parent's Signature: ______________________

Are you interested in Sedation? ❑ Yes ❑ No

**Our Referral Co-ordinator will contact you to schedule your consultation and obtain your $100 deposit over the phone. The consultation fee must be paid in advance to reserve your appointment. All treatment costs are due at the time of service.**

519-756-8080 lcarver@clarencestreetdental.com
1325 Clarence St S, Unit 1, Brantford, ON N3S 0C7