Periodontic Referral

Dr. Jacob Swiderski, 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
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Note: _____

_____

_____

Type of treatment:

- ❑ Surgical Crown Lengthening
- ❑ Guided Tissue Regeneration
- ❑ Extraction & Dental Implant
- ❑ Tissue Grafting
- ❑ Gingival Recontouring
- ❑ Generalized Assessment
- ❑ Ridge Augmentation

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 as a form of payment.**

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