Patient-Led Specialist Requisition

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

Clarence Street DENTAL Group

Patient's Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Referring Clinician: _____

Clinic Phone: _____

Clinic Email: _____

What is your main concern? _____

Type of Specialist Needed:

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

Sedation Needed: ❑ Yes ❑ No

To help our team set you up for success with our specialty services, please sign below to have your x-rays forwarded to Clarence Street Dental. Having your x-rays will help the specialist prepare for your consultation and possibly prevent new x-rays from being taken.

I hereby authorize Clarence Street Dental to obtain my dental x-rays and records in regards to my upcoming specialist consultation.

Patient/Parent's Name: _____

Patient/Parent's Signature: _____

Date: _____

Once your referral request has been received, a member of our team will reach out to schedule your consultation and obtain your $100 deposit over the phone. Taking care of the deposit reserves the appointment and is required to book. All treatment costs are due at the time of service.

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