Periodontic Referral

Dr. Jacob Swiderski, DDS, FRCD (C)

Clarence Street
DENTAL Group

Please email the ***completed*** referral form to info@clarencestreetdental.com or fax it to 519-756-0745.

Patient's Name: ______________________________

Date of Birth: ______________________________

Phone: ______________________________

Email: ______________________________

Referring Clinician: ______________________________

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

Notes: ______________________________

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Type of Treatment:

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

Sedation Needed: ❑ Yes ❑ No

X-rays being sent with referral: ______________________________

Payment is due at the time of service via debit, cash, Visa, or MasterCard. We submit insurance claims on our patients' behalf and the insurance company will reimburse them directly. We regret to inform that we do not accept ODSP or HSO as a form of payment with our specialists.