Truro Dental Specialists
510 Prince St., Truro, NS B2N 1G1
Phone: 902-843-3330
Email: Reception@TruroDS.com

REFERRAL TO:

☐ **Dr. Louis Bourget**
Oral & Facial Surgery
Implant Therapy

Referring Dentist:_____

Telephone _____ Fax _____ Email _____

PATIENT NAME (First)_____ (Last) _____ D.O.B. _____

Provincial Health Card # _____ Parent/Guardian Name _____

Street Address _____

City _____ Province _____ Postal Code _____

Telephone (Home)_____ (Cell) _____ Email _____

Dental Insurance ☐ NONE ☐ COMMUNITY SERVICES ☐ GROUP/PRIVATE INSURANCE

INSURANCE COMPANY NAMES (S) 1. 2.

Plan Holder Name _____ Insurance Plan Holder's D.O.B. _____

Relationship with Plan Holder ☐ SELF ☐ SPOUSE ☐ COMMON LAW ☐ DEPENDANT

PLAN/GROUP NUMBER(S) 1. 2.

ID/CERTIFICATE NUMBER(S) 1. 2.

REASON FOR REFERRAL AND ADDITIONAL TREATMENT PLAN INFO

MEDICAL HISTORY or MEDICAITONS OF NOTE : _____

PLEASE INDICATE THE AREA/TOOTH NUMBER(S) FOR TREATMENT

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Planned Restorative:
☐ Removable Overdenture CUD / CLD
☐ Fixed Implant Denture CUD / CLD
Conversion denture for implant dentures? YES / NO
Provisional denture required? YES / NO Already fabricated? YES / NO

Patient has:
Complete Denture ☐ upper/lower
Partial Denture ☐ upper/lower

Indicate tooth #s ☐ Crown(s) _____
Indicate abutments & pontics ☐ Fixed Bridge _____
☐ CUD / CLD / RPDL / RPDU
☐ Immediate Denture
☐ Other _____

The tooth to replace is still in place: YES / NO (If possible, it is preferable not to extract the tooth before we see the patient.)

X-RAYS ON FILE: ☐ PANORAMIC ☐ iTERO ☐ I-CAT (MUST HAVE I-CAT FOR IMPLANT RELATED TREATMENT)
MODELS INCLUDED? YES / NO

Signed: _____ Date: _____