WEST COAST
ORAL & MAXILLOFACIAL SURGERY

WE ARE REFERRING

Patient: _____ Gender: _____

Birth Date: _____ Guardian *(if applicable)* _____
(DD / MM / YYYY)

Address:

(City) _____ *(Postal Code)* _____

Phone: *(H)* _____ *(C)* _____

Patient email: _____

Referred by: _____ *(Phone #)* _____

Dental insurance info:

_____

Radiograph - Panoramic or PA only

☐ Take ☐ Emailed ☐ Mailed ☐ Given to Patient

Date Radiograph Taken _____

Appointment Information: This time is reserved specifically for you. If by necessity you must cancel your appointment for surgery, please notify us at least **three business days** in advance.

REASON FOR REFERRAL

- ☐ 3rd Molars
- ☐ Apicoectomy
- ☐ Extractions
- ☐ Expose & Bond
- ☐ Implants
- ☐ Frenectomy
- ☐ Augmentation/grafting
- ☐ Infection
- ☐ Botox
- ☐ Lesion
- ☐ Orthognathic
- ☐ Alveoplasty
- ☐ Jaw Fracture / trauma
- ☐ Facial Rejuvenation / Cosmetic Filler
- ☐ Other:

_____

Please indicate teeth to be removed or surgery to be performed

Comments: _____

_____

_____

_____

We request payment for office services at the time they are provided. For your convenience, we accept Visa, Mastercard, and direct debit. We will be pleased to submit your applicable claim form upon completion of your treatment so that you can be reimbursed for your portion directly by your dental insurance carrier.

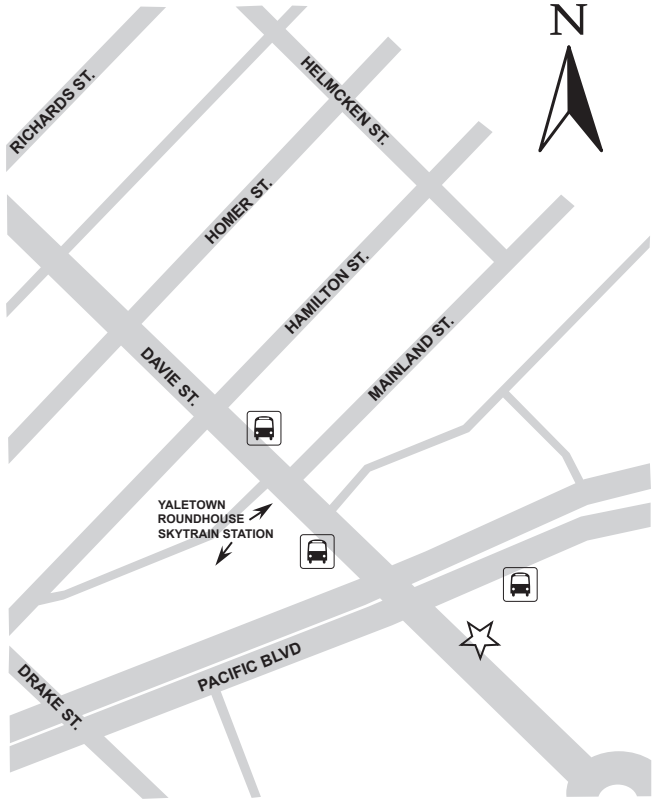
☐ **Yaletown**
#209 - 179 Davie Street, Vancouver, BC V6Z 2Y1
p 604-688-7781 **f** 604 683 2203
e vancouver@westcoastoralsurgery.ca

☐ **Port Coquitlam**
#230 - 2755 Lougheed Hwy, Port Coquitlam, BC V3B 5Y9
p 604-464-6833 **f** 604 464 3168
e portcoquitlam@westcoastoralsurgery.ca

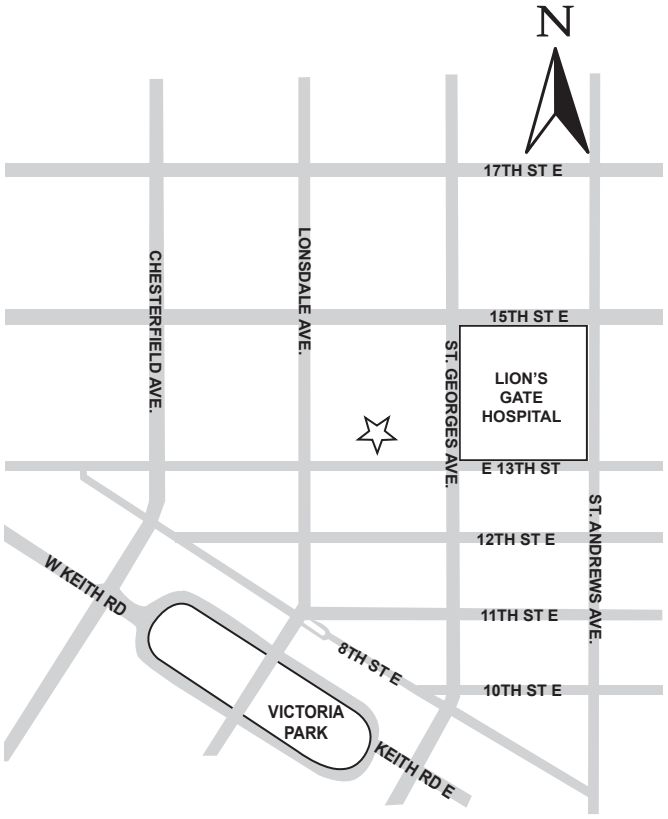
☐ **North Vancouver**
#370 - 138 E 13th Street, North Vancouver, BC V7L 0E5
p 604-416-2670 **f** 604 416 2678
e northvancouver@westcoastoralsurgery.ca

Please forward this referral by fax or email to our office.

230 - 2755 LOUGHEED HIGHWAY
PORT COQUITLAM, BC



209 - 179 DAVIE STREET
VANCOUVER, BC



370-138 EAST 13TH STREET
NORTH VANCOUVER BC