ATLANTIC
Oral Surgery & Facial Reconstruction Centres

DATE _____

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

Street Address _____ City _____

Province _____ Postal Code _____ Gender: ☐ M ☐ F ☐ X

Telephone (Home) ( ) _____ (Cell/Work) ( ) _____ Email _____

Provincial Health Card # _____ Parent/Guardian (Last) _____ (First) _____

Dental Insurance ☐ NONE ☐ INS. COMPANY/PROVIDER _____ ☐ MSI/ESA (Must Provide HC#)

Plan Holder Name (Last) _____ (First) _____

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

Insurance Plan Holder's D.O.B. _____ Employer of Plan Holder _____

PLAN/GROUP NUMBER _____ ID/CERTIFICATE NUMBER _____

LOCATIONS *(Please indicate preference of location for your patient)* / SURGEON

☐ DARTMOUTH ☐ TRURO ☐ BRIDGEWATER ☐ NFLD (Gander) | *Louis A. Bourget*

APPOINTMENT ☐ ASAP ☐ ELECTIVE ☐ HAS BEEN BOOKED (Date: _____ Time: _____)

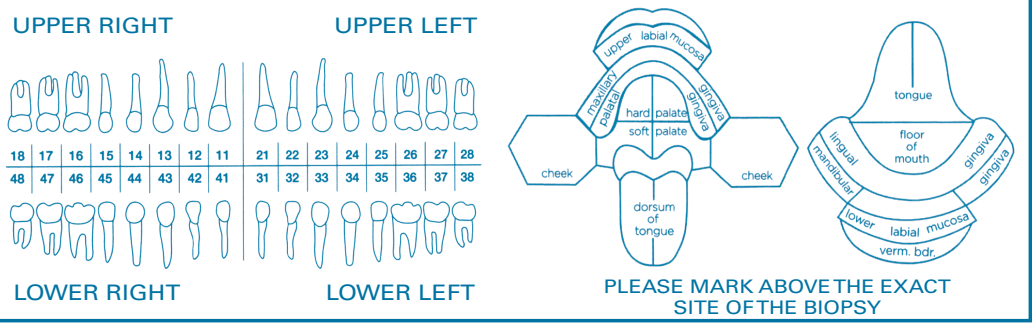
X-RAYS ☐ PLEASE TAKE ☐ Attached (PAN or PA only) DATE TAKEN: _____

REFERRING DOCTOR (Last Name) _____ (First) _____

Telephone ( ) _____ Fax ( ) _____ Email _____

REASON FOR REFERRAL

☐ Implants _____
☐ Extractions _____
(Please indicate on chart to the right)
☐ Expos & Bond
☐ Orthognathic Surgery
☐ TMD/Oro-Facial Pain
☐ Pathology
☐ CBCT



PLEASE MARK ABOVE THE EXACT SITE OF THE BIOPSY

MEDICAL HISTORY or MEDICATIONS OF NOTE _____

NOTES:

_____

_____

_____

_____

Atlantic Oral Surgery & Facial Reconstruction Centres

18 Acadia Street, Dartmouth NS B2Y 4H3 | P 902 334 0700 F 902 406 1730 | 500 Prince Street, Truro, NS B3A 4H5 | P 902 843 3330 F 902 843 2998
42 Glen Allan Drive, Suite 205, Bridgewater NS, B4V 3N2 | P 855 474 2672 F 902 406 1730 | 91 Roe Avenue, Gander, NL A1V 1W8 | P 709 381 6637 F 709 381 6638
TF 855 474 2672 | reception@aosahfx.com | www.AOSFRC.ca