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REFERRAL FORM

Patient's Name: _____ D.O.B: _____

Address:_____

City: _____ Province: _____ Postal Code: _____

Home #: _____ Cell #: _____

Patient's Email: _____

Parent (Guardian) Name: _____

Reason for referral: _____

_____

Medical Concerns: _____

_____

Radiographs: ___Taken
___ Emailed
___ Please Take

Referring Doctor: _____ Phone #: _____

Office Name: _____ Fax #: _____

Office Email: _____

Financial Policy: We do not accept assignment of insurance benefits. Full payment for any treatment rendered is due at the time of appointment. Our office will assist in the completion and submission of any necessary insurance forms.