415 Bloor Street West Suite 300
Toronto, Ontario M5S 1X6

Patient Referral Form

If you need an Immediate Appointment, please call our office at **(416) 538-8883** and talk to our staff and we will try to accommodate your patient.

Referring Doctor/Dentist	
Doctor's First Name*	
Doctor's Last Name*	
Doctor's Telephone Number*	
Doctor's Email Address*	
Patient Information	
Patient's First Name*	
Patient's Last Name*	
Date of Birth (mm/dd/yyyy)	
Address (Line 1)*	
Address (Line 2)*	
Email Address*	
Cell Phone*	
Home Phone*	
Insurance Coverage*	☐ YES | ☐ NO If yes, which company?

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Are there X-Rays Available?	☐ YES | ☐ NO Please email any X-Rays to **dentistry@bloordental.com**
Radiographs to follow	☐ By Email | ☐ Via Post Mail
Reason for Referral	☐ TMJ ☐ Sleep Apnea ☐ Orthodontics ☐ General Dentistry ☐ Other (please explain)

We thank you for your referral and will contact your office to confirm intake. If there is anything we can do to serve you better, **please let us know.**