# HOLLINGER DENTAL GROUP

PERIODONTIST REFERRAL - **Dr. Michael Coyne**
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TEL: 705-267-1020 ▪ Fax: 705-268-8350

PATIENT INFORMATION DATE :_________________
PATIENTS'S NAME: ______________________________________ DOB: ____________ M___ or F____
TELEPHONE NUMBER: (H): ______________________________ (M): ______________________________
ADDRESS: ______________________________________________________________________________
PATIENT EMAIL: ___________________________ REFERRING DENTIST: ___________________________

INSURANCE DETAILS
INSURANCE COMPANY: ______________________ INSURANCE HOLDER: ___________________________
GROUP#: _____________ CERTIFICATE#: ______________________ DOB: __________________________
2nd INSURANCE: _____________________________ INSURANCE HOLDER: __________________________
GROUP#: _____________ CERTIFICATE#: ______________________ DOB: __________________________

PERIODONTAL REFERRAL DETAILS:
☐ GENERALIZED EVALUATION: _____________________________________________________________
☐ SPECIFIC EVALUATION: ________________________________________________________________
☐ PRE-ORTHO EXAM: ____________________________________________________________________
☐ CROWN LENGTHENING: _________________________________________________________________
☐ SOFT TISSUE GRAFT: __________________________________________________________________

IMPLANT REFERRAL:
☐ IMPLANT LOCATION: __________________________________________________________________
☐ BONE GRAFT: _______________________________________________________________________
☐ SINUS LIFT: ________________________________________________________________________

OTHER:
☐ ORAL PATHOLOGY / BIOPSY: ____________________________________________________________
☐ TOOTH EXPOSURE: ____________________________________________________________________

MEDICAL HISTORY:
☐ Pre-medication ☐ Other: _______________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

ON RECALL EVERY: ______MONTHS MOST RECENT SCALING ON: ______________________
DATE OF X-RAYS: _______________ DATE OF PHOTO's: _____________________

COMMENTS:____________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

***Please include current vertical x-rays, photos and periodontal charting. (photos needed especially for grafts & biopsy's) E-mail: specialists@hollingerdental.ca or CDA Secure**