FRASER VALLEY
ORAL & MAXILLOFACIAL SURGERY

DR. GARRY GILL BSc, DMD, FRCD(C), Dip ABOMS, FADSA, Dip NDBA, FAAOMS
Certified Specialist in Oral and Maxillofacial Surgery
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REFERRAL

PATIENT NAME: _____ D.O.B. _____ (MM/DD/YYYY)

ADDRESS _____ PHONE _____

DENTAL INSURANCE INFO

1ST POLICY HOLDER _____ D.O.B. _____ (MM/DD/YYYY)

INSUR. CO. _____ SUBSCRIBER ID _____ GR# _____

2ND POLICY HOLDER _____ D.O.B. _____ (MM/DD/YYYY)

INSUR. CO. _____ SUBSCRIBER ID _____ GR# _____

TREATMENT

			55	54	53	52	51	61	62	63	64	65			
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
			85	84	83	82	81	71	72	73	74	75			

- ☐ EXTRACTION
- ☐ BONE GRAFTING
- ☐ TRAUMA
- ☐ IMPLANT CONSULTATION
- ☐ BIOPSY CONSULTATION
- ☐ OTHER
- ☐ EXPOSURE/EXPOSE & BOND
- ☐ CONEBEAM CT SCAN

RADIOGRAPHS

☐ ENCLOSED ☐ GIVEN TO PATIENT ☐ EMAILED ☐ TAKE XRAY

COMMENTS

REFERRING DOCTOR _____ DATE _____

☐ SEND MORE REFERRAL FORMS

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WELCOME TO OUR PRACTICE

- If appointment is not pre-booked, please arrange appointment by calling 604.756.1940
- Nothing to eat or drink for 8 hours prior to surgery
- Please take all medications with a sip of water at regularly scheduled times, unless otherwise stated
- Please bring a list of af all medications you are currently taking
- A responsible adult must accompany the patient if sedation is planned
- All patients under the age of 18 must be accompanied by a parent or guardian

APPOINTMENT FORM

Date _____ Time _____

You have been referred for specialized care to an Oral and Maxillofacial Surgeon. We are committed to providing you with the highest of care possible. If by necessity you must cancel your appointment, please notify us at least 48 hours in advance.