



Pediatric Dentistry and Orthodontics – Dr. Sergio J Weinberger

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London, ON N5Y 3H9

6 Millenium Way
Kincardine, ON N2Z 0B5

911 Yonge Street
Walkerton, ON N0G 2V0

REFERRAL INFORMATION

PLEASE NOTE: ALL requested information in this form must be completed to avoid any delays in booking consultation appointment.

- This is a consultation appointment only. **Duration-Approximately 2 Hours**
- Cancellation notice of **3 business days** is required for any appointment to avoid a **cancellation charge of \$250.00.**
- **Parent/Guardian is responsible for providing an interpreter on the day of the appointment.**

Date: _____

1. SOURCE OF REFERRAL Other (specify): _____

Referring DDS MD: _____

Last Name **First Name**

Address: _____ City _____ PC: _____

Phone #: _____ Fax #: _____ Email: _____

2. PATIENT INFORMATION: New Patient Previous Patient

Any siblings referred to our office before? Name: _____ Yes No

Patient's Name: _____ M F

Last Name **First Name**

DOB: ____/____/____ Medical Concern: _____

dd **mm** **yy**

Address: _____ City _____ PC: _____

Home Phone #: _____ CP: _____ Other: _____

Parent/Guardian: _____

Last Name **First**

Name Email Address: _____

3. CUSTODY ISSUES: No Yes (bring Proof of Custody on the day of consultation appt)

Legal Guardian: _____

Last Name **First Name**

Home Phone #: _____ CP: _____ Other: _____

4. INSURANCE TYPE: (Please circle all appropriate)

No Insurance Private HSO # _____ Exp: _____

CAS-CITY: _____ → GSC Other: _____

Signing Authority: _____ (MUST BE PRESENT ON THE APPT DAY)

Last Name **First Name**

Phone #: _____

5. REASON FOR REFERRAL:

- Caries/Age Beh Pain Scope of treatment Restorative Needs
 Orthodontics 1st Dental Visit Other: _____

Dentist Main Concern. please specify in detail.

If Trauma-Date: _____

Description of the Incident:

6. Please be as detailed as possible. This allows us to establish a history and idea of how to proceed with treatment.

How was the patient's previous experience/cooperation within your office?

Have you completed any restorative procedures on this patient? No Yes (**Please specify treatment rendered and date**)

Recall/NPE (last Date): _____

Radiographs (most recent) Yes Date Taken: _____ No

e-mailed with parent mail
_____ #BW _____ #↑ / ↓OCC _____ #PA _____ PAN _____ Other

Please email all appropriate radiographs with patient's name and date taken in the subject line to referrals@pediatricdentistry.ca

“For Pediatric Dentistry and Orthodontics use only”

Consult

Duration: approximately 2Hrs

Parent/Guardian must be present on the day of the consultation day

Payment Policy:

Payment Due -Day of Visit Visa/Mc/Debit/Cash \$_____ + x-rays (if needed)

Cancelation Policy:

3 Business Days' Notice Requires (if Less-rebooking fee of \$250.00)

Explained/Booked with: _____

Appt Date: _____

Booked By: _____