SASKATOON DENTURE CLINIC LTD

REFERRAL FORM

COMPLETE & PARTIAL DENTURE SERVICES

James G. Hoffart DD, Licensed Denturist
Chelsea B. Schreiner DD, Licensed Denturist
Kelsey M. Reiber DD, Licensed Denturist

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Telephone Res: _____ Cell: _____ Bus: _____

Email: _____

Insurance Company: _____ Policy #: _____ ID #: _____

NIHB ID #: _____ Supplementary Health #: _____

Missing Teeth:

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

Teeth Requiring Extraction: _____

Extraction Date: _____ ☐ **X-Rays Included**

- ☐ Complete Upper Denture
- ☐ Complete Lower Denture
- ☐ Immediate Complete Upper Denture
- ☐ Immediate Complete Lower Denture
- ☐ Partial Upper Denture
- ☐ Partial Lower Denture
- ☐ Immediate Partial Upper Denture
- ☐ Immediate Partial Lower Denture
- ☐ Acrylic Partial Upper Denture
- ☐ Acrylic Partial Lower Denture
- ☐ Removable Prothesis on Implants
- ☐ Fixed Prothesis on Implants

Outstanding Hygiene, Restorative Treatment to be Completed: _____

_____

Referring Dentist: _____ Phone Number: _____

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