ATLANTIC | ORAL SURGERY & DENTAL IMPLANT CENTRE

Full-Time Oral & Maxillofacial Surgeons
Dr. Shannon Davis
Dr. Rebecca Woodford
Dr. Fadhel Gazala

Locum Oral & Maxillofacial Surgeons
Dr. Nicholas Ledderhof
Dr. Navraj Sandhu
Dr. Sina Hashemi

Oral Medicine & Oral Pathologist
Dr. Firoozeh Samim

PATIENT INFORMATION

Today's Date _____

First Name _____ M.I. _____ Last Name _____

D.O.B. (yy/mm/dd) _____ Gender ☐ M ☐ F ☐ X

Address _____

City _____ Province _____ Postal Code _____

Email _____

Telephone (C) _____ (H) _____ (O) _____

MCP _____ Expiration Date _____

Parent/Guardian Name _____ ☐ Yes, patient has consented to electronic communication.

REFERRING DOCTOR INFORMATION

Referred by _____ Telephone _____

Email _____

REASON FOR REFERRAL

☐ Extraction _____

Implants:

☐ Single _____

☐ Multiple _____

☐ Full Arch _____

☐ Orthognathic Surgery

☐ Expose and Bond

☐ Pathology

☐ Oro-facial Pain

☐ TMD

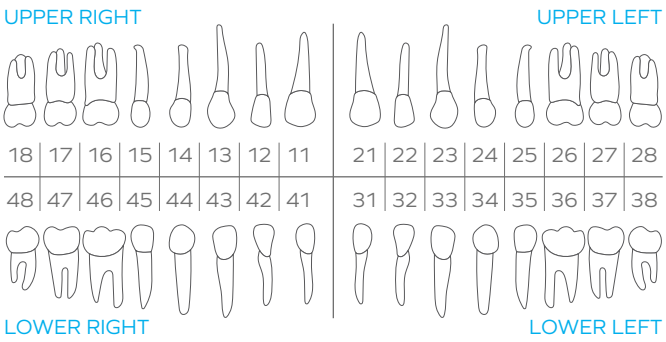
☐ CBCT

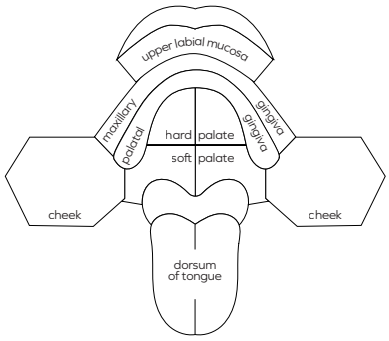
☐ Other _____

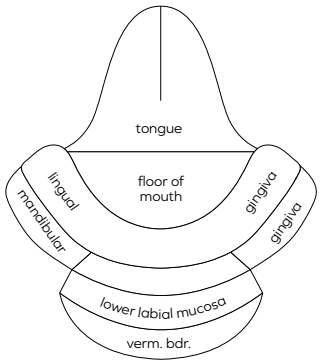
ANESTHESIA

☐ Local Anesthesia ☐ IV Sedation ☐ General Anesthesia

REFERRED TO _____ *indicate doctor preference* ☐ No Preference







PLEASE MARK ABOVE THE EXACT SITE OF THE BIOPSY.

Verify teeth for extraction _____

IMAGING

☐ Emailed ☐ No Imaging Date _____

If radiographs are included please indicate the date image was acquired

APPOINTMENT TYPE

☐ Initial Consultation ☐ Consultation/Same Day Surgery

COMMENTS _____

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