GILLIS
DENTAL IMPLANTS

Referring Dentist Details

Full Name: _____ Referral Date: _____

Address: _____

_____ Postal Code: _____

Telephone: _____ Email: _____

Patient Details

Full Name: _____ Date of Birth: _____

Address: _____

_____ Postal Code: _____

Telephone (H): _____ Email: _____

Telephone (W): _____

Telephone (C): _____ x-ray attached / x-ray emailed / no x-ray (circle one)

Referral Type:

- ☐ Implant placement
- ☐ Implant placement and restoration
- ☐ Implant restoration
- ☐ Site development (grafting)
- ☐ CBCT
- ☐ Guide (3d printed with steel sleeves based on cbct and model data)
- ☐ Complication management
- ☐ Consultation (planning assistance)

Area of concern: Indicate teeth involved

1-8	1-7	1-6	1-5	1-4	1-3	1-2	1-1	2-1	2-2	2-3	2-4	2-5	2-6	2-7	2-8
4-8	4-7	4-6	4-5	4-4	4-3	4-2	4-1	3-1	3-2	3-3	3-4	3-5	3-6	3-7	3-8

Details:

590-5991 Spring Garden Rd
Halifax, NS, B3H 1Y6
B3H 1Y6
(902) 405-0077
admin@gillisdentalimplants.com