Horizon Dental

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PATIENT REFERRAL

Patient: _____ (Male/Female/They/Them) DOB: Y_____/M_____/D_____

Parents/Legal Guardian:_____ Primary Phone: _____

Address:_____

Email: _____ Alt. Phone:_____

DENTAL INSURANCE INFORMATION

Primary Carrier:_____ Insured:_____ Insured's DOB:_____

Group/Policy Number:_____ ID/SIN:_____ Basic%:_____ Major%:_____

Secondary Carrier:_____ Insured:_____ Insured's DOB:_____

Group/Policy Number:_____ ID/SIN:_____ Basic%:_____ Major%:_____

REASON FOR REFERRAL/PATIENT HISTORY

Areas of Concern:_____

◯ Treatment attempted, was unsuccessful - please describe: _____

◯ Anxious/timid but cooperative ◯ Not cooperative/does not engage with dental team ◯ Needle phobia

◯ Cannot tolerate rubber dam ◯ Sensory request: _____

◯ Differently abled/neurodiversity – please describe: _____

◯ Patient has had sedation previously – when/where/was it successful?:_____

◯ Patient/Parent has requested sedation ◯ Patient may require sedation ◯Transfer of care

◯ X-rays Enclosed ◯ X-rays Emailed ◯ Unable to take X-rays as patient could not tolerate

REFERRING DENTIST

Name:_____ Telephone:_____

Office Name:_____ Address:_____

Email:_____ Signature:_____

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IMPORTANT – PLEASE GIVE THIS PORTION TO PATIENT/PARENT

Patients & Parents:

1) You or your child has been referred to us by your dentist for treatment.

2) Treatment will NOT be performed on the first visit.

3) Parents/legal guardians MUST attend this consultation visit with their child.

4) Please leave siblings at home whenever possible.

5) Please advise us if you or your child has medical and/or behaviour issues we should know about?