Kurt Fuoco
DENTURE CLINIC
P: 519-336-2731 F: 519-336-2941
635 Cathcart Blvd. Sarnia, ON N7V 2N1

Patient Referral

Referring Dr: _____ Date: _____

Patients Name: _____

Date of Birth: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Insurance: _____

Denture Required

	Upper	Lower
	☐ Complete	☐ Complete
	☐ Partial	☐ Partial
	☐ Immediate	☐ Immediate
	☐ Implant Removable	☐ Implant Removable
	☐ Implant Fixed	☐ Implant Fixed

Is there any future dental work planned/needed?

☐ Yes ☐ No

Date completed/expected to be completed.

☐ Hygiene Apt Date: _____ _____
☐ Extractions - Tooth #_____ _____
☐ Root Canal - Tooth #_____ _____
☐ Fillings - Tooth #_____ _____
☐ Other _____ _____

Additional Notes: