VILLAGE WALK
DENTAL SURGERY & SPECIALTY GROUP

200 Village Walk Boulevard, Suite 100 London, ON N6G 0W8
Tel: 226-636-2222
Email: reception@villagewalkdental.ca

REFERRAL FORM – ORTHODONTICS
Treated by an Orthodontic Team

Referring Doctor: _____ Office: _____
Patient: _____ DOB: _____ Gender: M / F
Address: _____
City: _____ Postal Code: _____
Telephone: (Home) _____ (Cell) _____ Email: _____

Consultation is requested for:
Orthodontic *(Initial Consult: No Charge)*

☐ Crowding/Spacing ☐ Class II Malocclusion ☐ Class III Malocclusion ☐ Excessive Overjet ☐ Excessive Overbite
☐ Congenitally Absent Teeth ☐ Other:
_____

Additional Comments:_____
_____

Relevant Medical History:
_____
_____
_____

Referral Checklist:
☐ IO Photos & Patient Profile Pic *(if available)*
☐ PAN
☐ CEPH
☐ Tracker Patient Info – including notes from the date of the appointment that prompted referral

Referral Form Completed by:_____

Assignment is NOT accepted, although claims will be submitted electronically on behalf of the patient.

Completed by: