glo ORTHODONTICS

37 Ella Lane, Unit 100
Bedford, NS, B4B 2J6

Dr. Matthew Brown & Dr. Ric Bezanson

Patient Referral Form

Date: _____

Referring Doctor (Last Name): _____ (First): _____

Telephone: _____ Fax: _____ Email: _____

Patient Information

Patient Name (Last): _____ (First): _____

DOB: _____ Age: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Cell: _____ Email: _____

Patient's preferred method of communication: ◯ Mail ◯ Phone ◯ Email

Parent/Guardian: (Last Name): _____ (First): _____

Dental Insurance

Insurance Company Name: _____

Policy/Group #: _____ Certificate/ID #: _____

Plan Holder Name (Last): _____ (First): _____

Relationship to Plan Holder: Self Spouse Common Law Dependent

Insurance Plan Holder's D.O.B: _____ Employer of Plan Holder: _____

Reason For Referral: _____

_____

_____

Medical & Dental History or Medications of Note: _____

_____

_____

Additional Information:

Please schedule Patient: ◯ ASAP ◯ Elective Has Been Booked: (Date)_____ Time: _____

Other Enclosures:

I would prefer your Orthodontic Diagnosis and treatment plan sent to me:

◯ By Letter ◯ By Fax ◯ Electronically ◯ By Telephone ◯ By Courier