470 Groves Avenue
Kelowna, B.C.
Canada V1Y 4Y5

Dr. J. David Gainey Inc.
Certified Specialist in Periodontics and Dental Implants

Email: reception@okperio.ca
Email: drgainey@okperio.ca
Tel: (250) 763-1111
Fax: (250) 763-6509

A. WE ARE REFERRING:

Patient: ☐ M ☐ F // ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ________________________________ Birth Date:___/___/___ (Day/Month/Year)

Address: ____Postal Code: _________________

Telephone: (Res) ______________________(Bus) ______________________ (Cell) ___________________________

Email: ____

Date of Referral:___________________ Time in Practice: ☐ New ☐ _______Yrs. Active Recall: ☐ Yes ☐ No

Has this patient been seen in our office before? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Primary Carrier: __________________________ Insured: _____________________________

Group Policy Number: _____________________ ID/S.I.N.: _____________________________

Employer: _______________________________ Insured's D.O.B.:_______________________

Secondary Carrier: ________________________ Insured:______________________________

Group Policy Number:______________________ ID/S.I.N.: _____________________________

Employer:________________________________ Insured's D.O.B.: ______________________

B. REASON FOR REFERRAL

☐ Complete Periodontal Evaluation: ____
____
____

☐ Specific Area Periodontal Evaluation in an otherwise healthy mouth:
(Please comment on specific location and nature of problem)____
____
____
____

☐ Special Considerations:____
____
____

C. DATED RADIOGRAPHS

☐ Periapical radiograph(s) enclosed
☐ Full mouth series enclosed
☐ Please take a new radiographic survey
☐ No diagnostic radiographs available

Referred by Dr. ____________________________

Please email, mail, or fax this referral form to us and we will contact the patient immediately to arrange an appointment. Thank you in advance for your continued trust and confidence.