| Date of Referral: |             |
|-------------------|-------------|
| Referring Dr:     | <del></del> |
| Practice Name:    |             |



## **PATIENT INFORMATION**

| FULL LEGAL NAME:  |  |
|---|--|
| ☐ Male ☐ Female Identifies As (if applie  | cable):DOB:  |
| Parent/Responsible Party Name:  | Same household?  |
| Parent/Responsible Party Name:  |  |
| Address:  |  |
| Primary Cellphone #:  |  |
| Secondary or Home Phone #:  |  |
| Email:  |  |
| INSURANCE Government Plan (if applicable Primary Company:   | ole) Disability Child in Care FNHA Cleft Palate Secondary Company: |
| Plan Holder Name:   | Plan Holder Name:  |
| Date of Birth:  | Date of Birth:   |
| Employer <u>:</u>   | Employer:  |
| Group or Plan # <u>:</u>  | Group or Plan #:   |
| ID or Certificate:  | ID or Certificate:   |
| Ortho Coverage %: Max \$:   | Ortho Coverage %: Max \$:  |
| Waiting Period?   | Waiting Period?  |
| Age Limit?  | Age Limit?   |
| REFERRAL INFO   |  |
| General Orthodontic Evaluation Crossbite/Functional Shift Crowding Growth/Skeletal Imbalance Impacted Teeth Minor Tooth Movement Missing Teeth Openbite Orthognathic Surgical Evaluation Pre-Prosthetic Alignment Space Maintenance Spacing | Other Notes/Concerns:  |

Please send the completed form to our office. If available, include the most recent PAN and perio charting with your referral.

Email: info@shuswaportho.com Fax: 250.832.1166

Thank you for your referral!

250-832-6558

✓ Info@shuswaportho.com

Suite 202 - 571 6th St NE Salmon Arm, BC V1E 1R6