Sunnybrook
HEALTH SCIENCES CENTRE

Department of Dentistry
2075 Bayview Avenue., Suite H126
Toronto, Ontario, Canada M4N 3M5
Tel: 416-480-4436
Fax: 416- 480-5757

Please advise your patient that OHIP does not cover dental care.
The Department of Dentistry charges fees consistent with generalist (ODA) and specialist fee guides. Payment is required at time of service. Assignment from insurance companies is not accepted.

PLEASE PRINT CLEARLY. INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED

Patient Information:

Male ☐ Female ☐ Date of Birth: ______/______/______
Year / Month / Day

Print name exactly as on Health Card

Name: ______________________________
Surname First name

Health Card #: ______________ ______
version code

Address: ______________________ Phone: H: ______________
______________ ______ B: ______________
City Postal Code C: ______________

Reason for Referral:

- General dental care ☐
- IV deep sedation ☐
- Extractions ☐ (specify tooth numbers)
- Periodontics ☐
- Endodontics ☐

Specialty surgical services:

- Impacted tooth/teeth ☐
- Dental implants: ☐
- Orthognathic/ reconstructive surgery ☐
- Surgical pathology ☐
- Maxillofacial trauma ☐

Additional Details:

Medical History:

Medications:

Allergies:

Referring Practitioner Information:

Physician: _____ Dentist: _____ Specialty if applicable: ___________ OHIP Billing Number (if applicable): ___________
Name: ______________________________
Address: ______________________________
Telephone: ______________________ Fax: ______________________

For office use only: Date received: ______________ Triaged by: ___ Priority: ______________
Referral accepted _____ Not accepted: Returned for more info ☐ Redirected ☐
Date and time of appointment: ______________ Notification: Patient ☐ Referring doctor ☐
Appointment with: ______________________
Hospital file number: ______________ Account number: ______________