Sunnybrook
HEALTH SCIENCES CENTRE

Oral and Maxillofacial Surgery
DR. NICK BLANAS/DR. SANTINO BAMBARA/DR. PETER TA
Department of Dentistry
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Please note: Dental services are not covered by OHIP.
There will be a charge for consultation and radiographs.
Payment is due 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:

Orthognathic/Reconstructive Surgery:

Dental Extractions:

Endodontic Surgery:

Dental Implants:

Pathology:

Exposure and Bonding:

TMJ Dysfunction:

TADS:

Trauma/Other:

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: _____