WESTCOAST ORAL & MAXILLOFACIAL SURGERY

DR. ANTHONY REA INC.

B. Sc., D.M.D.,Dip.N.D.B.A., F.R.C.D. (C)

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Ph: 250-370-7066 Fax: 250-370-1983
Email: referrals@westcoastos.com

WE ARE REFERRING

Patient Name: _____

DOB: _____ Parent/Guardian: _____
Please note: Minors must be accompanied by a Parent/Guardian

Address: _____

Phone (h): _____ (c): _____

Email: _____ (w): _____

DENTAL INSURANCE INFORMATION

FIRST DENTAL PLAN:

Policy Holder's Name: _____

Employer: _____ DOB: _____

Insurance Company: _____ Basic Coverage: _____

Group: _____ ID: _____ Division: _____

SECOND DENTAL PLAN:

Policy Holder's Name: _____

Employer: _____ DOB: _____

Insurance Company: _____ Basic Coverage: _____

Group #: _____ ID #: _____ Division: _____

REFERRAL INFORMATION

Dr. Anthony Rea
☐ **Radiograph emailed**
☐ **Radiograph enclosed**
☐ **Please take panorex**

☐ Extraction

				E	D	C	B	A	A	B	C	D	E		
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
				E	D	C	B	A	A	B	C	D	E		

☐ Biopsy
☐ Exposure
☐ TMJ
☐ Fracture/Trauma
☐ Other _____

☐ Pathology
☐ Orthognathic Surgery
☐ Endosseous Implants
☐ Cosmetic Botox/Facial Filler Rejuvenation

☐ Preprosthetic Surgery
☐ Augmentation/Grafting

COMMENTS: _____

DATE: _____

REFERRED BY: _____ **PH:** _____

APPOINTMENT BOOKED: _____

PLEASE COMPLETE IN FULL