Langford DENTURE CLINIC

Patient Referral Form

#103 685 Fairway Ave
Langford BC V9B 2R6 Tel: 250-478-0708
www.langforddentures.ca Langforddentures@shaw.ca

Date:____________________

This form is available electronically on the clinic's website.

Patient Info:

Name____

Address____

Phone#__________________________Email__________________________

DOB____________________________

Insurance Info:

Primary Carrier:____

Group #:__________________________Policy#:__________________________

Spouse Name (if a dependant):____________________DOB:____________________

Referring Dentist Info:

Dentist Name: ______________________________Phone #: ____________________

Dental Office:____

Reason For Referral:

CUD CLD PUD PLD

Additional Notes: