Dr. Ronald J. Shupe Inc.

Certified Specialist in Prosthodontics

(250) 860-6939
Fax: (250) 860-6933
Toll Free: 1-800-661-4288

#115 - 1890 Cooper Road
Kelowna, B.C. V1Y 8B7

We are referring:

A.

Patient: ____________________ Birthdate: ____________________

Address: ____

City: ____________________ Postal Code: ____________________

Telephone: (Res) ____________________ (Bus) ____________________

DENTAL INSURANCE INFORMATION:

Primary Carrier: ____________________ Insured: ____________________

Group Policy Number: ____________________ ID/S.I.N.: __________ Dep. Code: __________

Employer: ____________________ Insured's D.O.B.: ____________________

Basic%: __________ C&B%: __________ Prosth.: __________ Ortho.: __________

Secondary Carrier: ____________________ Insured: ____________________

Group Policy Number: ____________________ ID/S.I.N.: __________ Dep. Code: __________

Employer: ____________________ Insured's D.O.B.: ____________________

Basic%: __________ C&B%: __________ Prosth.: __________ Ortho.: __________

B. REASON FOR REFERRAL:

❑ Consultation Re: ____

❑ Treatment (as requested)
(Please provide specialist with appropriate details of problem, i.e. urgency, areas of concern, using F.D.I. tooth number system).

C. RELEVANT HISTORY:

(Indicate any special factors, either dental or medical, such as known allergies, specific medical problems relevant to diagnosis and treatment).

D.

- ❑ Please Call the Patient
- ❑ Patient Will Call
- ❑ An Appointment Has Been Made
- ❑ Radiographs Enclosed
- ❑ Please Return Radiographs After Use
- ❑ Other Records Available

- ❑ Please Report - ❑ Written
  - ❑ Phone
- ❑ Post Referral Maintenance - ❑ By Specialist
  - ❑ In This Office
  - ❑ To Be Discussed
- ❑ Notify On Completion

YOUR OFFICE STAMP HERE

Signed: ____________________

Date: ____________________

FORM 1002