DR. MARK OLIVITO
AND ASSOCIATES

REFERRAL FORM

PATIENT NAME _____ ☐ MALE ☐ FEMALE ☐ _____

PARENT/GUARDIAN NAME (if applicable) _____

ADDRESS _____ POSTAL CODE _____

PHONE _____ CELL/OTHER # _____

BIRTHDATE _____ /_____ /_____ DATE OF REFERRAL _____ /_____ /_____
DD MMM YYYY DD MMM YYYY

REASON(S) FOR REFERRAL:

☐ **SEDATION**	☐ **EXTRACTIONS**	☐ **RESTORATIVE**	☐ **IMPLANTS**
☐ **ORTHODONTICS**	☐ **ENDODONTICS**	☐ **CBCT (COMPLETE PAGE 2)**	☐ **OTHER**

_____

_____

REFERRED BY _____ PHONE _____

EMAIL _____

EMAIL RADIOGRAPHS AND REFERRAL TO olivitodentistry@bellnet.ca

We look forward to meeting you at the appointment which has been reserved for you on:

_____ /_____ /_____ at _____
DD MMM YYYY

PLEASE REVIEW THE FOLLOWING DETAILS WITH THE PATIENT UPON REFERRAL:

1. This initial visit to our office may be for consultation only. This enables your dental needs to be evaluated so that any other appointments that are appropriate for your individual care can be arranged.
2. Scheduling an appointment with our office is confirmation you will be here. Should an appointment need to be changed 2 business days' notice is required.
3. Payment & Dental Insurance
   - ✓ Payment is due at the time of service
   - ✓ If applicable, insurance claims will be submitted to the insurance company and reimbursement will be sent directly to the patient.
   - ✓ When scheduling a sedation appointment, a deposit of 25% or $500 is required. This is a non-refundable deposit that reserves the time for your needed sedation treatment.
   - ✓ Cash, Debit, Visa or MasterCard are accepted.

DR. MARK OLIVITO
AND ASSOCIATES

REQUISITION FOR CONBEAM C.T. (CBCT) SCAN

CBCT FEE $320 (01204 Specific Exam $120; 07011 CBCT Acquisition $95; 07032 CBCT Interpretation $105)
FEES INCLUDE: CBCT scan, scan on USB, interpretation, report and delivery. No additional charges for nerve mapping or DICOM conversion.

PATIENT NAME_____ ☐ MALE ☐ FEMALE ☐ _____

ADDRESS_____ POSTAL CODE_____

PHONE_____ CELL/OTHER #_____

BIRTHDATE_____ /_____ /_____ DATE OF REFERRAL_____ /_____ /_____
DD MMM YYYY DD MMM YYYY

REFERRING DDS_____ PHONE_____

REFERRING DDS EMAIL_____

AREA TO BE SCANNED & REASON_____

RELEVANT PATIENT HISTORY_____

RADIOGRAPHIC STENT/MARKED DENTURE/APPLIANCE PROVIDED BY YOU: ☐ YES ☐ NO

NERVE MAPPING REQUIRED: ☐ YES ☐ NO

ADDITIONAL REQUEST(S)_____

I WOULD LIKE THE SCAN: ☐ EMAILED VIA CDA NET ☐ ON USB DRIVE

I WOULD LIKE THE FILES IN FORMAT: ☐ DICOM ☐ GALAXIS

RECENT PAN/PA's MUST ACCOMPANY REFERRAL
EMAIL RADIOGRAPHS AND REFERRAL TO olivitodentistry@bellnet.ca

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87 MAIN ST E KINGSVILLE, ON N9Y 1A3 519-733-2325 www.kingsvilledentistry.com