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Dr. Karl Cuddy, BSc, DDS, MD, MSc, FRCD(C)
Dr. Sean S Tjandra, BSc, DDS, MSc, Dip. OMFS, FRCD(C)

REFERRAL FORM

Patient's Name: ____ D.O.B: _____________________

Address:____

City:__________________ Province: __________________ Postal Code: ______________

Home #: _____________________________ Cell #: _________________________________

Patient's Email: ____

Parent (Guardian) Name: ____

Reason for referral: ____

____

Medical Concerns: ____

____

Radiographs: ___Taken
___ Emailed
___ Please Take

Insurance:_________________________ Policy/Plan number
________________________ I.D/ Certificate number
________________________ Name of Insurance Company
________________________ Name of Employer
________________________ Name of Insured
________________________ Date of Birth of Insured

Referring Doctor: ___________________________ Phone #: ________________________

Office Name: ______________________________ Fax #: ____________________________

Office Email: ____

Financial Policy: We do not accept assignment of insurance benefits. Full payment for any treatment rendered is due at the time of appointment. We require 5 business days for cancellations or changes to appointment times. Our office will assist in the completion and submission of any necessary insurance forms.