MARVIN BUDD B.Sc.,D.D.S.
PERIODONTICS & IMPLANTOLOGY

ROYAL BANK BUILDING, 508-111 GRANGEWAY AVE.
SCARBOROUGH, ONTARIO M1H 3E9
TEL: 416-431-0400 FAX: 416-431-2745

Fax Referral

No Cover Sheet Required

From: _____ **Date:** _____

To: **Dr. Marvin Budd** **Fax No:** **(416) 431 – 2745**

Patient Information

Patient: _____

Address: _____

Home Tel: _____ **Bus Tel:** _____

Dental History

Requires Premedication: ❑YES ❑NO **Allergic to Penicillin:** ❑YES ❑NO

❑ **New Patient** ❑ **Active Patient** ❑ **Recare every _____ months**

❑ **Recent Scaling** **Date:** _____

Reason For Referral

❑ **Complete Periodontal Evaluation** ❑ **Implant #** _____

❑ **Crown Lengthening #** _____ ❑ **Gingival Recession #** _____

❑ **Other #** _____

Radiographs

# of Periapicals: _____ **Date:** _____ **DDS Sending?** ❑YES ❑NO

# of Bitewings: _____ **Date:** _____ **Given to Patient?** ❑YES ❑NO

Additional Comments that would help us in providing treatment to your patient