



Prosthodontist Dr. Mark Lin Dr. Bo Huang Dr. Max Li
Periodontist Dr. Jae W. Chang
Endodontist Dr. Alice F.C. Li
Dental Anesthesiologist Dr. Stephen Ing

Referral Form

PATIENT INFORMATION

First Name: _____
Last Name: _____ Title: _____
Date of Birth: _____ DD/MM/YY
Address: _____

Tel: _____
Email: _____

REFERRING DOCTOR INFORMATION

First Name: _____
Last Name: _____
Practice: _____
Address: _____

Tel: _____
Email: _____

Preferred Languages: English Cantonese Mandarin Others: _____

REASON(S) FOR REFERRAL, CHECK ALL THAT APPLIES

Prosthodontic

Dental Implant (s)
Implant Complications
Full Mouth Reconstruction
Fixed Prosthodontics
Removable Prosthodontics
Bone Grafting/Augmentations
Cosmetic/Aesthetic Dentistry
Second Opinion
Others (please specify in notes)

Periodontic

Periodontal Evaluation
Deep Pockets/Furcation Involvement
Crown Lengthening
Recession/Soft tissue grafting
Specific Surgical Exam
Unerrupted Tooth Exposure
Orthodontic Co-therapy
Biopsy/Oral Lesion Evaluation
Others (please specify in notes)

Endodontic

Consultation Only
Root Canal Treatment
Retreatment
Apical Surgery
Post Space Preparation
Restore Endodontic Access
Tooth Bleaching
Other (Please specify in notes)

CBCT

Dental Implants Evaluation
Pathology
Preferred Implant System

CBCT _____
Pan _____

Radiographic Guide Provided Yes No

Previous Radiographs

Sent with patient Emailed

Date of x-rays: _____

TORONTO DENTAL SPECIALISTS

88 Finch Ave East, North York, Ontario M2N 4R5
Tel: 416-221-2950 / 1-888-7-DRLIN-8
Fax: 416-221-6396
smile@oralhealth4life.net
www.oralhealth4life.net

UPPER RIGHT

18 17 16 15 14 13 12 11

LOWER RIGHT

48 47 46 45 44 43 42 41

UPPER LEFT

21 22 23 24 25 26 27 28

LOWER LEFT

31 32 33 34 35 36 37 38

NOTES:

OUR TEAM



Dr. Mark Lin
Prosthodontist



Dr. Bo Huang
Prosthodontist



Dr. Max Li
Prosthodontist



Dr. Stephen Ing
Anesthesiologist



Dr. Alice F.C. Li
Endodontist



Dr. Jae W. Chang
Periodontist

Please be advised that the appointment time has been exclusively scheduled for you. We respectfully request three business days' notice if you must reschedule your appointment. We do not accept cancellations via email or phone message. Please call to reschedule your appointment accordingly. Otherwise, a cancellation fee will be charged for missed appointments or short notice cancellations.

Please bring or email in advance the following to your scheduled appointment:

This referral form

Any radiograph(s) given to you by your own dentist

Any other relevant/Important information of history regarding your case

Appointment Date: _____ **Time:** _____



Free parking is available in the
back of the building
Close to Finch Subway station



CONSULTATION FEE

45-minute appointment \$180

CBCT

One Quadrant \$250

One Arch \$375

Two Arches \$420



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