DENTURE CLINIC CORP.

Unit 2 - 543 Ellis Street, Penticton, BC V2A 4M4
250-809-4751 sbdentureclinic@gmail.com
www.sbsmiles.net

Referral Form/Prescription Form

PATIENT INFORMATION

Patient Name: ______________________________ Referral Date: ____________________

Phone: ________________________ Email: _________________________________

REFERRAL INFORMATION

Doctor's Name: ______________________________ Phone: ______________________

Office Name: ____

REASON FOR REFERRAL

New Denture Consult

- Cast partial denture(s)
- Acrylic/flexible partial denture(s)
- Immediate denture(s)
- Intra-oral check

Implant Treatment Options

- All-On-4
- Bar-retained denture
- Denture on locators

Other

Additional Services

- Tooth addition
- Add to partial
- Other

Comments: ____

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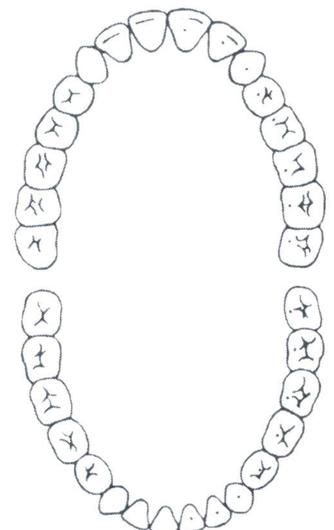

Dentist
Signature: ________________________________