DENTURE CLINIC CORP.

543 Ellis Street, Penticton, BC
V2A 4M4

250-809-4751
sbdentureclinic@gmail.com

REFERRAL/PRESCRIPTION FORM

Date of Referral: _____

Dentist: _____

Office: _____

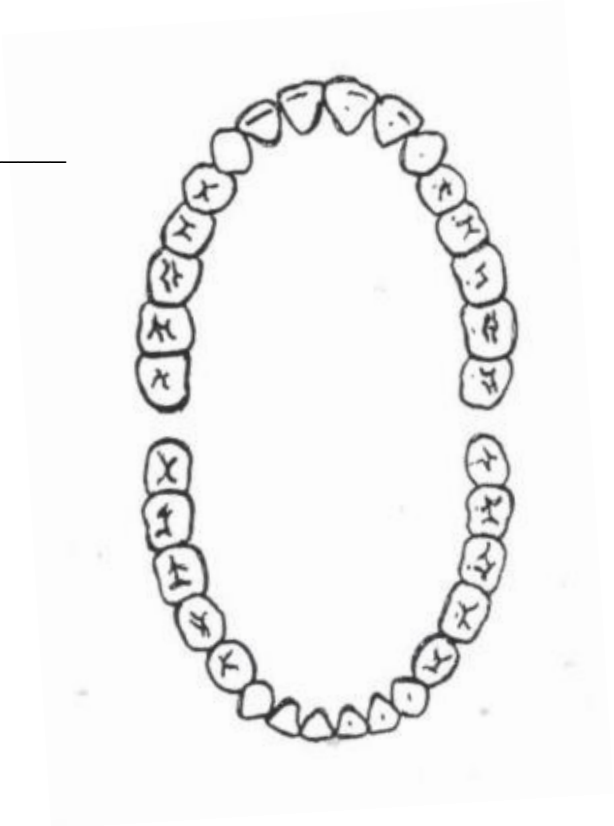
Patient Information:

Patient Name: _____

Phone Number: _____

Patient Spouse Name (For Insurance Only): _____

Patient Spouse DOB: _____



Insurance Information:

Primary

Insurance Company: _____

ID Number: _____

Group Number: _____

Secondary

Insurance Company: _____

ID Number: _____

Group Number: _____

Appliance Needed:

Cast Partial ☐ Immediate Denture ☐ Post Immediate Denture ☐

Denture on Implants (Removable Only) ☐ Repair/Reline/Tooth Addition ☐

Rest Preps, Date: _____ ☐

Notes:

_____

_____

Signature: _____