Dr. Keelen D Tymkiw
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Certified Specialist in Periodontics
Dental Implants
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Referral for Periodontal Consultation

Date: ______________________________

Prefer Patient to be seen at:
☐ Kelowna Office ☐ Vernon Office ☐ First Available

Patient Information

Male ☐ Female ☐

Name: ______________________________ DOB: ____/____/____
MM / DD / YYYY

Address: ______________________________

City: ______________________________ Postal Code: ______________

Home Ph: ______________________ Other Ph: ______________________

Email: ______________________________

Insurance Information

Primary ☐	Secondary ☐
Name of Insured: ______________	Name of Insured: ______________
Employer: ______________	Employer: ______________
Plan Name: ______________	Plan Name: ______________
Policy #: ______________	Policy #: ______________
ID#: ______________	ID#: ______________
DOB: ______________	DOB: ______________

Radiographs: ☐ None ☐ By Mail ☐ w/Patient ☐ By email

Reason for Referral

- ☐ Comprehensive Exam
- ☐ Specific Site Assessment
- ☐ Gingival Augmentation
- ☐ Crown Lengthening
- ☐ Extraction & Socket Pres
- ☐ Ridge/Sinus Augmentation
- ☐ Exposure of Unerupted Tooth
- ☐ Oral Pathology
- ☐ Esthetic Evaluation
- ☐ Other (*pls comment below*)

Dental Implant

- ☐ Astra
- ☐ Nobel Biocare: ☐ *Active* ☐ *Nobel Replace*
- ☐ Straumann: ☐ *Bone Level* ☐ *Tissue Level*
- ☐3i
- ☐Other: ______________

Comments

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Referred by: ______________ Phone: ______________ Email: ______________