THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Dentistry

UBC Graduate Program Clinics
2151 Wesbrook Mall, Vancouver, BC V6T 1Z3
Tel: 604-822-8078 Fax: 604-822-3708

Date: _____

PATIENT:

Name: _____ Date of Birth: _____
Address: _____
Telephone (home) _____ (work) _____ (cell) _____
E-mail:_____

Dental Insurance: ☐ Yes ☐ No

Radiograph attached: ☐ Yes ☐ No Mailed separately: ☐ Yes ☐ No

REFERRING DENTIST:

Name: _____
Address: _____
Telephone: _____ Fax: _____
Email: _____

REFERRAL TO GRADUATE PROGRAM(S):

(for Endodontics use Endo Referral Form)

☐ Orthodontics
☐ Pediatric Dentistry
☐ Periodontics
☐ Prosthodontics

REASON FOR REFERRAL: **TOOTH #** _____

MEDICAL HISTORY / ALERTS: