



# OCEANFRONT

ADVANCED COSMETIC + IMPLANT DENTISTRY  
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## REFERRAL FORM

### PATIENT INFORMATION:

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET CITY PROV. POSTAL CODE

Phone: \_\_\_\_\_

Insurance Details: \_\_\_\_\_

### REFERRED BY:

Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### REFERRED FOR:

Tooth/Area of Concern: \_\_\_\_\_

**IV sedation**

#### Restorative:

- Composite veneers
- Porcelain veneers
- Crown and Bridge
- Full mouth rehabilitation - dentulous
- Full mouth rehabilitation - implant-supported (FP1, FP2, FP3)
- Implant restorations
- TMD therapy (including botox)

**Invisalign**

#### Surgery:

- Wisdom teeth extraction
- Tooth extraction
- Implant placement (including surgical guide)
- Full mouth rehabilitation - implant-supported, removable or fixed prostheses (2-8 implants)
- Immediate implant placement - cosmetic area (with temporization)
- Bone grafting - autograft/allograft/xenograft
- Sinus grafting - SA2 (bump)/SA3 (lateral window)
- Gingival grafting - CTG/FGG/allograft (alloderm)

### ADDITIONAL NOTES:

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\_\_\_\_\_

\_\_\_\_\_

Enclosures:     Radiographs     CBCT     Med Hx     Other: \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature