



**DR. LESLEY A. DAVID**

ORAL & MAXILLOFACIAL SURGEON

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PATIENT NAME \_\_\_\_\_ PHONE # \_\_\_\_\_  
DATE \_\_\_\_\_

REFERRED BY \_\_\_\_\_ . THANK YOU FOR THE REFERRAL.

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	E D C B A	A B C D E
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	E D C B A	A B C D E

**EXAMINATION REQUESTED FOR:**

- IMPLANT(S) +/- SOFT TISSUE & HARD TISSUE GRAFTING
- EXTRACTION(S) / IMPACTION
- ORTHODONTIC EXPOSURE
- OTHER

IMPLANT SYSTEM PREFERENCE \_\_\_\_\_

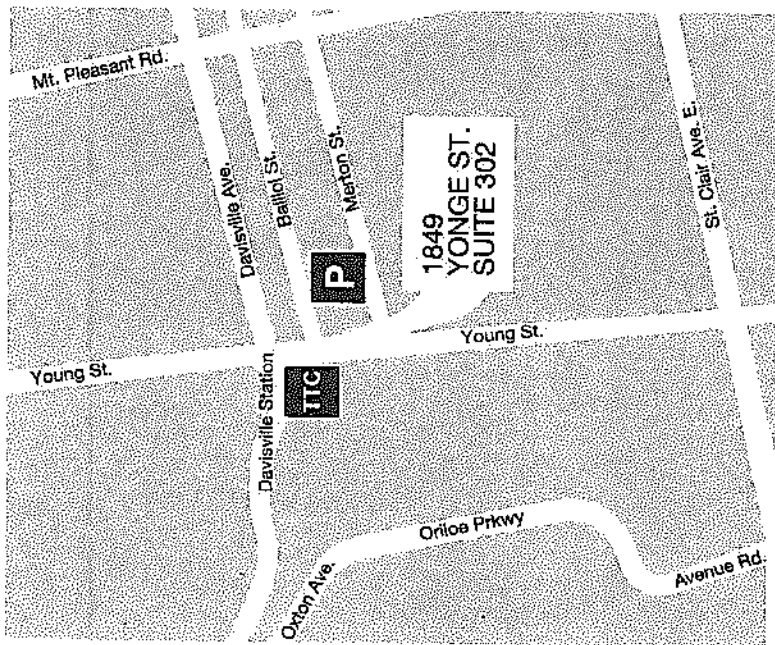
COMMENTS: \_\_\_\_\_

**RADIOGRAPH:**

- GIVEN TO PATIENT  E-MAILED
- MAILED  PLEASE TAKE

APPOINTMENT: DATE \_\_\_\_\_ TIME \_\_\_\_\_

48HRS NOTICE IS REQUIRED FOR ANY APPOINTMENT CHANGES.



**DIRECTIONS & PARKING**

Subway access at Davisville Station. Parking available on Yonge St. & parking lot on Merton St. shown above.

**NOTICE**

Your appointment may include general anaesthesia or intravenous sedation. Please do not eat or drink anything for 8 hours prior to surgery and have a responsible adult accompany you home. Please bring your referral slip, any pertinent x-rays, and any insurance information.