North Shore Oral Medicine

Dr. Maryam Taleghani
DMD, FRCDC, Dip ABOM
Certified Specialist in Oral Medicine

Date: _____

Patient's Name: _____

Birthdate: _____ ☐ M ☐ F

Home # _____ Bus/Cell# _____

Reason for Referral ☐ Consultation Only ☐ Consultation & Management

☐ Oral Mucosal Disorder
☐ Temporomandibular joint disorder
☐ Orofacial pain
☐ Other (Please Specify)

History

Please email or fax this referral form to our clinic.
Ask patient to call the clinic to arrange an appointment time.

Referred by Dr. _____

Tel. _____ Fax _____

Email_____

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