

ELIGIBILITY

**FAX COMPLETED FORM TO:  
(519) 539-9111**

Eligible clients must (please check to confirm eligibility):

- Be over 18-64 years old
- Have a low income OR be from a marginalized population; AND
- Have no dental benefits and be ineligible for Ontario's Seniors Dental Program

Please note: This clinic does not provide emergency dental services\*\*

CLIENT INFORMATION

\*Required Field

\*Name: \_\_\_\_\_ \* DOB (Y/M/D): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\* Address: \_\_\_\_\_ \*City: \_\_\_\_\_ \*Province: \_\_\_\_\_ \*Postal Code: \_\_\_\_\_

\* Phone: \_\_\_\_\_ \*Email: \_\_\_\_\_

\* Family Physician Name: \_\_\_\_\_ \* Number: \_\_\_\_\_ \* Fax: \_\_\_\_\_

\* Pharmacy Name: \_\_\_\_\_ \* Number: \_\_\_\_\_ \* Fax: \_\_\_\_\_

Insurance Coverage (If Applicable):  
 ODSP  NIHB  OW  Spouse/Partner  Other: \_\_\_\_\_

MEDICAL INFORMATION

I Agree to allow OCCHC permission to disclose any medication I have on file with a pharmacist or your doctor

Last Dental Visit: \_\_\_\_\_

\*Reason for Referral (Required): \_\_\_\_\_

Pain, Specific \_\_\_\_\_  Extraction  Check-up / Full Evaluation  Pain, General

Cavity  Other: \_\_\_\_\_

Please include a summary of the client's medical history and medications, if available: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I acknowledge that all required fields are completed, and I am aware that if any required information is missing, the referral cannot be processed

I agree that the Community Dental Clinic can contact referral source regarding any appointment  YES  NO

Do you have transportation to attend an appointment  YES  NO

Do you have a CDCP card?  YES  NO

Do you have a current dentist?  YES  NO

REFERRAL SOURCE:

\*Name: \_\_\_\_\_ \* Agency: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*Address: \_\_\_\_\_ \* City: \_\_\_\_\_ \* Province: \_\_\_\_\_ \* Postal Code: \_\_\_\_\_

\*Date: \_\_\_\_\_ Signature: \_\_\_\_\_