SINGHAL DENTISTRY

Cone Beam (CT) Scan Imaging Referral Form

Please fill in the form below and e-mail it to InfoGlebe@singhaldentistry.ca, fax it to (613) 233-2001, or call us at (613) 233-2000 for an appointment.

Referral Details Please print clearly

Referring Dentist Name:	Patient Name:
Dentist Telephone:	Patient Date of Birth: DD/MM/YYYY
Dentist E-mail:	Patient Telephone:
Dentist Address:	Patient E-mail:
Region of Interest:	Referral Reasons/Details:

Payment

We are a fee-for-service dental provider. **Payment is due in full at the time dental treatment is rendered.** We do not accept payment from insurance companies. If you have dental insurance, we will gladly submit your claim electronically, whereby you will be reimbursed directly by your insurance carrier.