Kids Dentistry.ca

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PATIENT REFERRAL

DOCTOR OFFICE TEL

PATIENT NAME DATE OF BIRTH

PARENT / GUARDIAN CELL / TEL. NUMBER ALT CONTACT (WORK TEL / EMAIL)

ADDRESS

[ ] Please Call Patient [ ] Patient will call office

INSURANCE ☐ Private ☐ CDCP ☐ NIHB ☐ None ☐ Other _____

Please provide as much information as possible so that we may take care of your patient.

REASON FOR REFERRAL

☐ Caries
☐ Trauma
☐ Abscess
☐ Crowding / Growth Anomaly
☐ Secontd Opinion
☐ Other _____

RADIOGRAPHS

☐ Please Take
☐ Given to Parent
☐ Mailed
☐ Emailed (info@kidsdentistry.ca)

CO-OPERATION

☐ Good ☐ Fair ☐ Poor

MEDICAL HISTORY

☐ Healthy ☐ Autism (verbal/non-verbal) ☐ Cardiac ☐ Diabetes ☐ Other _____

ADDITIONAL HEALTH DETAILS

YOUR CONCERNS & REQUESTS

PLEASE PORIVDE ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO HAVE OR SPECIAL REQUESTS FOR TREATMENT

SCAN ME

KidsDentistry.ca/referral/