REFERRAL FORM S ILE Well DENTAL

Section for Staf	Our Branches
• Referring Doc	INORTH VANCOUVER (778) 340-2897 nvwelldental@gmail.com 814 15th St W #202, North Vancouver, BC
• Referring Offi	ce's Name SURREY (9) (778) 877-3493
• Referring Office	ce Phone number info@smilewelldentalsurrey.com 15243 91 Ave #2, Surrey, BC
Date	DD / MM / YYYY Column
Patient Infomation	n en
Patient Name	Last First Date of Birth DD / MM / YYYY
Address	Postal Code
Contact <u>Cell</u>	Home
Dental Insurrance	Group Insurrance (1st) CDCP (no)
	Group Insurrance (2nd) No
Section for Dentist	
Medical Information	☐ Mental/ Physical issue ☐ Patient is on wheelchair ☐ Dental Anxiety ☐ Hard to anesthesize ☐ Gagging issue
X-ray Enclosed	Emailed Patient will bring the X-ray(s) No
Type of X-ray	Panorama CT PA BW *X-ray(s) was taken on DMY
TREATMENT NEEDED	□ I.V. Sedation □ N20 Sedation □ Surgical Extraction □ Implant □ Filling □ Others:Specify
	18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28 55 54 53 52 51 61 62 63 64 65
	85 84 83 82 81 71 72 73 74 75 48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38
Signature of Refer	ring Nantist