Children's Dentistry

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REFERRAL

Patient Information

Name: _____ □ M □ F □ other Birth Date: _____

Address: _____ Postal Code: _____

Parent(s)/Guardian: _____

Phone: Res: _____ Bus: _____ Cell: _____

This referral is for:

□ Dr. Gordon Payne □ Dr. Alana Fraser □ Dr. Sergio Weinberger □ No Preference

Consultation is requested for: (check all that apply)

□ caries □ infection □ trauma □ pathology □ management □ orthodontics

□ other _____

Medical History

□ healthy □ _____

Insurance

□ private □ none □ other _____

Records

□ bitewings (send both sides) □ periapicals □ panoramic □ photos

□ emailed □ coming with patient X-ray date: _____ □ no records

When treatment is complete, how would you like us to manage this patient?

□ refer back to your office □ keep patient here until older □ parent to decide

Referring Doctor

Name: _____

Office Location (if more than one): _____

Office Phone: _____

Email: _____

Date: _____

Thank you for your referral!