SIERRA DENTAL
ORAL SURGERY

Dr. Choo-Soon Kua

DDS, FRCDC

Certified Specialist in Oral and Maxillofacial Surgery

Patient Information:

Name: _____

Date of Birth (DD/MM/YYYY): _____

Email: _____

Phone: _____

Reason for Referral (select all that apply):

☐ Extractions:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Implants/bone grafting (specify site): _____

☐ Pathology (specify area): _____

☐ Other: _____

Comments:

Referring Doctor Information:

Dr.: _____

Referring Office: _____

Email: _____

Phone: _____

☐ **Sierra Dental Studio**
5462 Signal Hill Centre SW
Calgary, AB T3H 3P8
Phone: 403-297-9600
info@sierradental.ca

☐ **Sierra Dental Airdrie**
113 – 1300 Market Street SE
Airdrie, AB T4A 0K9
Phone: 403-768-1000
airdrieinfo@sierradental.ca