SIERRA DENTAL

Date _____

Dr. Choo-Soon Kua
DDS, FRCDC
Certified Specialist in Oral & Maxillofacial Surgery

Patient's Name _____

DOB _____ Phone Number _____

Email Address _____

Medical Alerts/Allergies/Concerns _____

_____

Referring Dentist

Name _____ Clinic _____

Email _____ Phone _____

Radiographs: ☐ Panoramic ☐ CBCT ☐ FMX ☐ BWs ☐ PAX

Reason for Referral (select all that apply):

☐ Extraction(s):

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

☐ Implants/Bone Grafting (specify site):_____

☐ Pathology (specify area): _____

☐ Other: _____

Comments:

403-297-9600
info@sierradental.ca