

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:**