Dr. Dove
DENTAL OFFICE

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Dr Dove ☐ **Dr Shin** ☐ **No Preference** ☐

Referring Doctor & Office: _____ Office phone: _____

Patient Information

Name:_____ Date of Birth: _____

Address:_____

Phone:_____

Reason for Referral

- ☐ Restorative
- ☐ Crown/Bridge/Veneers
- ☐ Endodontics
- ☐ Extraction/Wisdom teeth
- ☐ Implants
- ☐ Implant-supported dentures
- ☐ Difficulty with local anaesthetic?
- ☐ Anxiety/High gag reflex?

Sedation

☐ Yes, which one ☐ No

- ☐ Conscious sedation (N2O, oral/N2O, IV)
- ☐ General Anesthesia (Suitable candidates: ASA I & II) NOTE: we do not treat social services (ODSP, OW, etc) under GA in office

Treatment overview

_____
_____
_____
_____
_____

Medical history

_____
_____
_____
_____
_____

☐ Appointment booked _____
☐ Patient to call
☐ Call patient
☐ Radiographs ☐ Emailed ☐ Faxed ☐ Enclosed ☐ With patient ☐ None