REFERRAL TO OFFICE

DR. NILAVA GHATAK — **PEDIATRIC DENTIST**

Date: _____

Referring Doctor (s): _____

Referring Doctor Phone Number: _____

Patient Name: _____ Date Of Birth: _____

Phone Number: _____ Email: _____

Parent/Guardian Name: _____ Gender: ☐ Male ☐ Female

Reason For Referral: ☐ First Visit ☐ Toothache ☐ Decay ☐ Special Needs ☐ Trauma

☐ Other: _____

_____

Radiographs: ☐ None Available ☐ Sent with Patient
☐ Emailed to *info@niagaradentalspecialists.ca*

Significant Medical History: _____

_____

_____

_____

Insurance: ☐ Yes ☐ No

Dental Insurance Details: *Name & DOB of policy holder, Policy number & member ID number*

_____

_____

NIAGARA DENTAL SPECIALISTS
NIAGARADENTALSPECIALISTS.CA
1-8302 McLeod Road, Niagara Falls, ON L2H 0Y7
E: info@niagaradentalspecialists.ca | **F:** 905.356.1901