REFERRAL TO OFFICE

DR. SZE SEN SAMSON SO

GENERAL DENTIST
(oral surgery focus)

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: *(All procedures provided with sedation as needed)*

☐ Wisdom Teeth Removal ☐ Full Clearance ☐ Extraction Of Any Teeth Removal

☐ 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*

_____

_____

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