CHINOOK DENTAL GROUP

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:

Thank you for the confidence of your referral.

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