DENTAL SERVICE GROUP

Dentistry Under General Anesthesia & Sedation

Dr. Kirk Chambers | Dr. Ward Jickling | Dr. Harry Choriatis

www.dentalservicegroup.ca

please ensure all information is as complete as possible

first name _____ last name _____

date of birth _____ ☐ m / ☐ f email _____
day / month / year

parent /guardian name _____

address _____

city _____ postal code _____

phone (res) _____ (cell) _____ AHC # _____

reason for referral

- ☐ extractions (tooth # _____)
- ☐ bone & soft tissue grafting _____
- ☐ pediatric rehabilitation
- ☐ surgical exposure (area _____)
- ☐ implants (tooth # _____)
- ☐ root canals (tooth # _____)
- ☐ restorative dentistry (please attach BWs)

is T_X plan available? ☐ no ☐ yes ☐ emailed ☐ faxed

comments _____

_____

_____

_____

_____

GA and sedation patients will require a pre-op medical clearance, please see reverse

x-rays: ☐ mailed ☐ with patient ☐ emailed ☐ none date taken _____

insurance company _____

group/policy # _____ id/cert # _____

name of policy holder _____

policy holder's date of birth _____

policy holder's employer _____

insurance: ☐ self ☐ spouse ☐ child

referring clinic _____

doctor's full name _____

clinic phone _____

clinic email _____

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edmonton, alberta t5m 0h4
wheelchair accessible
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toll free: 1-888-322-2161
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