KAMLOOPS PEDIATRIC DENTISTRY

#310 - 1055 Hillside Drive, Kamloops, BC V2E 2S5

PHONE 778-471-1724 FAX 778-471-1734

info@kamloopspediatricdentistry.com

Consultation Request for

Name:______________________ Birthdate (Month/Day/Year):______________

Parents Names:______________________

Address:______________________

Day Phone:______________ Cell Phone:______________ Other Phone:______________

Email:______________________

Medical Alerts and/or Allergies:______________________

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Dental Insurance Co.:______________ Group #:______________ ID #:______________

Insurance Holder:______________ Insurance Holder Date of Birth:______________

Reasons for Referral Consultation Only ○ Dental Caries ○ Behaviour ○ Occlusal Guidance ○ Pathology ○ Dental Trauma ○

Radiographs Not Taken ○ Digital (Please Email to Us) ○

Remarks / Concerns:______________________

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Treatment Modality Requested or Recommended to Parent:

Behaviour Guidance with Local Anesthetic ○ Sedation & Local Anesthetic ○

General Anesthetic ○ None Requested / Recommended ○

Referring Dentist:______________________

Phone:______________ Email:______________

Address:______________________

Remarks / Special Concerns:______________________

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Patient to be returned to our office for ongoing treatment ○ Please see patient in your office for ongoing treatment ○

Please Detach Bottom Portion and Give to Patient Family

- -

1 - Your child has been referred to us by your dentist for treatment of a special problem.
2 - Treatment will ***NOT*** be performed on the first visit.
3 - Parents / legal guardians ***MUST*** attend this consultation visit with their child.
4 - Please leave siblings at home whenever possible.
5 - Please advise us if your child has medical and/or behavioural issues we should know about.
6 - We do not accept personal cheques. We accept VISA, Mastercard, debit, money order or cash.