

REFERRAL SERVICE FOR IMPLANTS, EXTRACTIONS & SEDATION

Referral Date: _____ Patient Name: _____

Patient Address: _____ Postal Code: _____

Phone (Home): _____ (Cell): _____

Email Address: _____ DOB: ____/____/____ ☐ M / ☐ F
D M YR

☐ 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

- | | | |
|--|---|--|
| ☐ Extraction(s) | ☐ IV Sedation | ☐ Please Call Me |
| ☐ Implant Surgery Only | ☐ Implant Supported
Overdenture Therapy | ☐ Urgent |
| ☐ Implant Surgery & Prosthetics | | ☐ Returning Patient |

Doctor's Comments:	Insurance Information:
☐ X-Rays Included Date of X-Rays:	
Referred by Dr:	Office Name and Phone Number:

***Please fill in the form and email to admin@kamloopsimplants.com or fax to 250.372.7109**

Thank you for entrusting your patients in our care. Your faith in our team is the greatest compliment we can receive.

DR. HO-YOUNG CHUNG, DDS

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