DR. DARREN DAHLMAN
DMD, FRCD (C)

Dr. Darren Dahlman
ORAL & MAXILLOFACIAL SURGEON

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E: info@westkelownaoralsurgery.ca

WE ARE REFERRING

Patient _____ Birth Date _____

Address _____ City _____ PC _____

Email _____

Tel. Res. _____ Cell. _____ Bus. _____

☐ Patient will call ☐ Please take radiograph ☐ Radiograph emailed

☐ Appointment is scheduled: ☐ Radiographs being sent ☐ Date radiograph taken:

_____ ☐ Radiographs enclosed _____

REASON FOR REFERRAL

				55	54	53	52	51	61	62	63	64	65		
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
				85	84	83	82	81	71	72	73	74	75		

☐ Extraction ☐ Pathology / Biopsy ☐ Bone Grafting

☐ Expose & Bond ☐ Implant Consultation

Comments _____

_____

_____

_____

_____

_____

Referred by Dr. _____ Date _____

IF PATIENT IS A MINOR

Father's Name _____ Mother's Name _____

Work or Cell Phone _____ Work or Cell Phone _____

DENTAL INSURANCE

Policy Handler's First Name _____ Last Name_____

Employer_____ Date of Birth _____

Insurance Company Name _____ Group Policy # _____

Certificate / ID # _____ Plan % _____ Dependant # _____

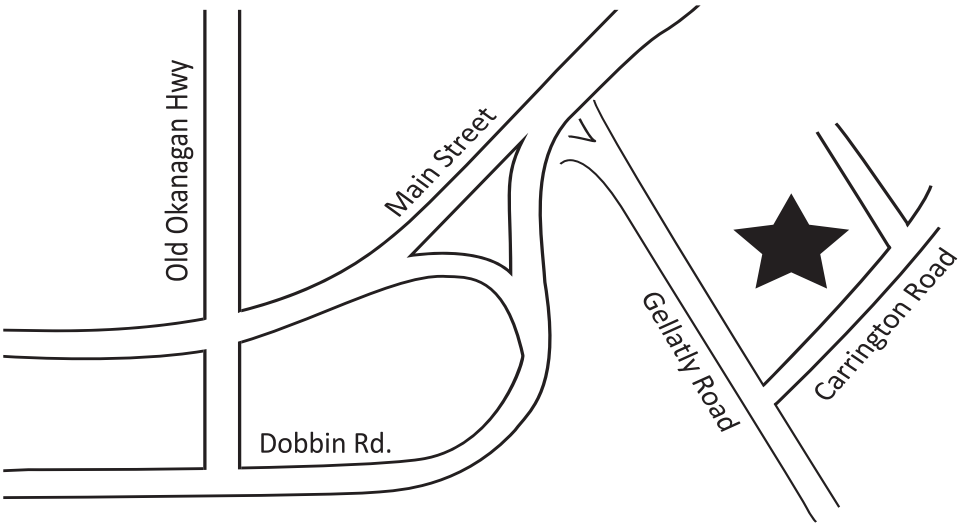
SECONDARY DENTAL PLAN

Policy Handler's First Name _____ Last Name_____

Employer_____ Date of Birth _____

Insurance Company Name _____ Group Policy # _____

Certificate / ID # _____ Plan % _____ Dependant # _____



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