Consultation Request

DATE

..... / ..... / .....

MICHELLE MCINTOSH *IVS/GA Restorations*
General Dentist

PATIENT .....

ADDRESS .....

CITY/TOWN ..... POSTAL CODE .....

PHONE (RES.) ..... (BUS.) .....

DATE OF BIRTH ...../...../..... A.H.C. # ..... – .....

Dental Insurance Company (1st) ..... *(2nd)* .....

Group & Policy # ....

Certificate or Coverage # ....

Employer ....

Employee ....

Ins. Holder's Date of Birth ....

MEDICAL HISTORY .....

.....

REFERRED FOR THE FOLLOWING .....

.....

RADIOGRAPHS AVAILABLE: *Yes* ◯ *No* ◯ DIGITAL: *Yes* ◯ *No* ◯

REFERRED BY .....

NOTES .....

.....

LETHBRIDGE DENTAL SURGICAL SUITES
Improving the Lives of Our Patients

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