GEORGIAN FAMILY DENTISTRY

Dial 1(519) 376-3225
referral@georgianfamilydentistry.com
1415 1st Ave W, Suite 1022 N4K 4K8, Owen Sound, ON
www.georgianfamilydentistry.com

Patient Information

Patient Full Name : _____

Phone Number : _____ DOB : _____

Email Address : _____

Select your Doctor

☐ Dr. Shreya Gakhar, Endodontics ☐ Dr. Cyril Joseph, Oral Surgery

Area of Concern

Tooth / Region Involved: _____

Clinical Information

Primary concern or diagnosis: _____

Anesthesia / Sedation

Anesthesia / Comfort Notes

☐ Local Anesthesia

☐ Sedation

☐ General Anesthesia (only for Oral Surgery)

☐ To Be Evaluated

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Supporting Records Included

Supporting Records Included

- [ ] X-rays
- [ ] CBCT Images
- [ ] Clinical Notes

Referring Provider

Dentist / Clinic Name: _____

Phone Number : _____

Email Address : _____

Date : _____ Signature : _____

Contact Information

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