

Patient Information

Patient Full Name : _____

Phone Number : _____ DOB : _____

Email Address : _____

Patients Full 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

Supporting Records Included

Supporting Records Included

X-rays CBCT Images Clinical Notes

Referring Provider

Dentist / Clinic Name: _____

Phone Number : _____ Email Address : _____

Insurance Information

Insurance Carrier : _____

Insurance Policy Number : _____

Insurance Certificate Number : _____

Insurance Policy Holder Name : _____

Insurance Policy Holder Date of Birth : ____/____/____

Date : _____ Signature : _____

Contact Information

☎ Dial 1(519) 376-3225

✉ referral@georgianfamilydentistry.com

📍 1415 1st Ave W, Suite 1022 N4K 4K8,
Owen Sound, ON

🌐 www.georgianfamilydentistry.com

