Dr. Prabhdeep Chahal, DMD, dip. PEDO, FRCD(C)
235-600 Crowfoot Cres NW, Calgary, AB T3G 0B4
Phone: (587)-356-TEAM (8326) Fax: (587)-356-8329
Website: www.thesmileteam.ca

Patient Referral Form

Patient name: _____ Date of Birth (month/day/year): _____
Name of Legal Guardian(s): _____
Address:_____
Phone number: □ Home: ( )- - □Cell: ( )- -
Email: _____
Preferred Method of Communication: □ Phone Home □ Phone Cell □ Text □ Email

Referring Doctor: _____Telephone number:_____

Reason for Referral:

- ○ Trauma
- ○ Toothache
- ○ Decay
- ○ First Dental Visit
- ○ Space Maintainer
- ○ Sedation/ Anesthesia
- ○ Special Needs
- ○ Extraction

Radiographs:

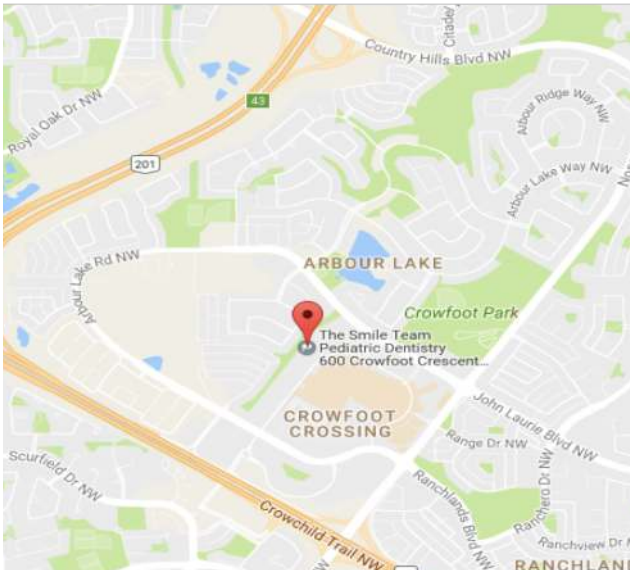
□ Sent with patient □ Emailed to: info@thesmileteam.ca □ None taken

Please let us know if there are specific teeth you would like us to evaluate:

Permanent Teeth															
Upper Right								Upper Left							
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
Lower Right								Lower Left							

Primary teeth									
Upper Right					Upper Left				
55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75
Lower Right					Lower Left				

Other information you would like to share with us:_____
_____
_____
_____
_____
_____
_____
_____
_____



INFORMATION FOR PARENTS/GUARDIANS:

★Free parking at front of building
★No Food or Drink in office please
★Please do not bring siblings to appointment
★Legal Guardian must accompany child
★Please submit completed patient forms (available on our website) at least 1 week prior to appointment

Thank you for giving us the opportunity to work together with you to care for this patient.