



Patient Referral Form

Patient name: _____ Date of Birth (month/day/year): _____

Name of Legal Guardian(s): _____

Address: _____ City: _____ Postal Code: _____

Phone number: Home: _____ Cell: _____

Email: _____

Preferred Method of Communication: Phone Home Phone Cell Text Email

Referring Doctor: _____ Telephone number: _____

Referring Office: _____ Date of last hygiene: _____

Information you can share with us regarding the patient's treatment needs and previous experience:

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				

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



Dr. Prabhdeep Chahal, DMD, dip. PEDO, FRCD(C)
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WEB: www.thesmileteam.ca EMAIL: info@thesmileteam.ca

*We look forward to
meeting your
family!*



Dr. Prabhdeep Chahal
DDS, M.Dent, dip PEDO, FRCD(C)

**INFORMATION FOR
PARENTS/GUARDIANS:**

Our office is located on the second floor
at the Crowfoot West Business
Centre.

Free parking at front of building
Please do not bring ANY food or drinks to
our office

Legal guardian must accompany patient
Please do not bring siblings to
appointments



***Thank you for allowing our team to work with you and
your children to achieve optimal oral health!***