ISLAND KIDS DENTISTRY
Andrew Tomash, DDS, FRCD(C)
Certified Specialist in Pediatric Dentistry
and Associates

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Dentist Referral:

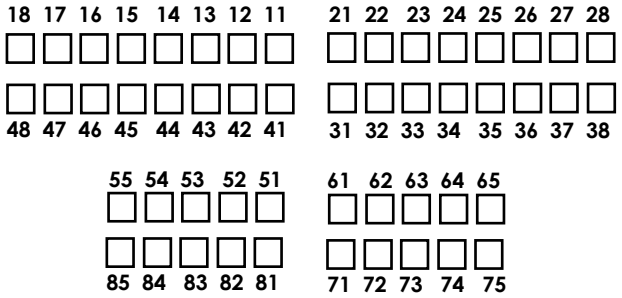
Patient Information:

Date of referral
Guardian: _____
Relationship to patient_____
Patient Name:_____ **Birthdate:**_____
Address:_____
City:_____ **Postal Code:**_____
Primary Number:_____
E-mail:_____

Dental Insurance Information:
Carrier Name:_____
Group#:_____**Certificate/ID Number:**_____
Policy Holder:_____
Policy Holder Date of Birth:_____
Employer:_____

Second Dental Insurance Information:
Carrier Name:_____
Group#:_____**Certificate/ID Number:**_____
Policy Holder:_____
Policy Holder Date of Birth:_____
Employer:_____

Reason for Referral:
- ☐ **Restorations**
- ☐ **Extractions (please indicate)**
- ☐ **Consultation**
- ☐ **Child has been difficult to handle**
- ☐ **Will require general anaesthetic**
- ☐ **X-rays enclosed**
- ☐ **No x-rays available**



Date of X-Ray **Uplozd X-Ray**

Comments:_____

_____

Referred by:_____ **Phone:**_____

Thank you for your referral to our office!