## **ISLAND KIDS DENTISTRY**

## Andrew Tomash, DDS, FRCD(C) Certified Specialist in Pediatric Dentistry and Associates



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## **Dentist Referral:**

Date of referral Guardian: Relationship to patient Patient Name: Address: City: Primary Number: E-mail:  Dental Insurance Information: Carrier Name: Group#: Policy Holder: Policy Holder Date of Birth: Employer:  Second Dental Insurance Information: Carrier Name: Group#: Certificate/ID Number: Policy Holder Date of Birth: Employer:  Second Dental Insurance Information: Carrier Name: Group#: Certificate/ID Number: Policy Holder: Policy Holder: Policy Holder: 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 Will require general anaesthetic X-rays enclosed No x-rays available  Date of X-Ray Uplozd X-Ray Comments:	Patient Information:									
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Referred by: Phone:	Referred by:	Phone:								

Thank you for your referral to our office!