RIVERWAY DENTAL

Dr. Wade Luksay Inc.

Patient's Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Phone (h): _____ Phone (c): _____ Email: _____

Referring Doctor: _____ Phone: _____

REFERRAL FOR DENTAL TREATMENT WITH MODERATE IV SEDATION:

- ☐ Restorative Dentistry including fillings and crowns
- ☐ Initial Endodontic Therapy including molar RCT with CBCT
- ☐ Complex Restorative Dentistry including implant restorations and quadrant dentistry
- ☐ Oral Surgery including complicated extractions, impacted wisdom teeth and full arch clearance

REASON FOR REFERRAL:

- ☐ Dental Anxiety
- ☐ Difficult Anaesthesia
- ☐ Claustrophobic with Rubber Dam
- ☐ Strong Gag Reflex
- ☐ Extensive Treatment Plan
- ☐ Other _____

PROPOSED TREATMENT PLAN:

MEDICAL ALERTS: _____

PRIMARY DENTAL INSURANCE: _____

SECONDARY DENTAL INSURANCE: _____

RADIOGRAPHS ATTACHED ☐

For Patient

RIVERWAY DENTAL

Dr. Wade Luksay Inc.

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