South Okanagan kids dental

Dr. Caroline Buttar
Pediatric dentist
DMD, MSc, FRCD(C)

Date: _____

Patient

Introducing: ☐ F ☐ M _____ D.O.B (D/M/Y): _____

Guardian: _____ Email: _____

Address: _____

City: _____ Postal Code: _____

Phone: (H)_____ (C) _____ (W)_____

Medical History: ☐ Allergies _____

☐ Prophylactic Antibiotics Required

Insurance Information

Primary Insurance Carrier: _____

Policy Holder: _____ D.O.B (D/M/Y): _____

Group Policy #: _____ I.D. #:_____

Coverage % P_____% B_____% M_____%

Secondary Insurance Carrier: _____

Policy Holder: _____ D.O.B (D/M/Y): _____

Group Policy #: _____ I.D. #:_____

Coverage % P_____% B_____% M_____%

NHIB: _____ **Healthy Kids:** _____

Other Coverage: _____

Reason for referral:

Please check all that apply

☐ Consultation Only
☐ Dental Caries
☐ Dental Habits
☐ Dental Trauma
☐ Extensive Dental Needs
☐ Medically Compromised & Special Health Care Needs
☐ Behavior Guidance
☐ Other: _____

Please Circle Area of Concern

Primary Dentition

5 4 3 2 1	1 2 3 4 5
5 4 3 2 1	1 2 3 4 5

Permanent Dentition

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Radiographs/photos:

☐ sent with patient ☐ sent directly (mail/email) ☐ none available ☐ please return after use

Follow Up:

☐ patient to continue care at kids dental ☐ refer back following treatment

Comments:

_____

_____

_____

_____

Referred by Dr. _____ Phone: _____ Email: _____
(Please Print)

Please print and return this form by fax, email or mail to the address below.

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