DENTAL DESIGN

BANKERS HALL ENDODONTISTS
Dr. Kim Fuhrman

Patient name: _____ Date of referral: _____

Cell Ph: _____ Home Ph: _____

Date of birth: _____ Email address: _____

Reason for referral: _____

_____

Referring Dentist: _____ Phone: _____

Did you provide any treatment, and were there any treatment complications?

_____

Medications prescribed? _____

Medical or dental history requiring special precautions? _____

Please forward info and current radiographs securely via:
Brightsquid (https://brightsquid.com) or
CDA Secure send (https://services.cda-adc.ca)

Date of appointment: _____

Phones (403)263-1343 or (403)278-2688
Suite 270, 6700 Macleod Trail S, T2H 0L3
Calgary, Alberta

Directions to our office on the internet at www.dentalyyc.com
Or refer to map on reverse of this form