COURTSIDE Dental

101 – 3725 Pasqua Street
Regina, Saskatchewan S4S 6W8
306-525-2577
reception@courtsidedental.ca

Referral Form for Dental Treatment with Sedation

Date of Referral: _____

Referred by Dr. _____ Referring Clinic: _____

Patient Name: _____ DOB: _____ Sex: ___

Address: _____ City/Prov: _____ Postal Code: _____

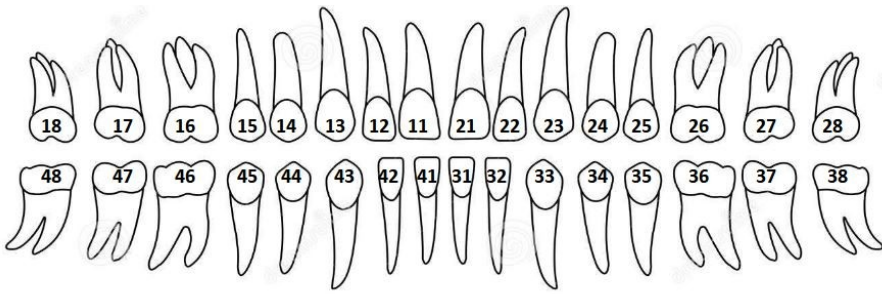
Phone Number: _____ Email: _____

HSN: _____ Treaty Number (if applicable): _____

Parent/Guardian (if under 18 years): _____ Relationship: _____

Treatment Requested:

Tooth/Teeth Requiring Treatment *(please circle)*



Medical History

☐ None
☐ Significant: _____
_____
☐ Special Needs: _____

Dental History *(provide copy of treatment plan if applicable)*

☐ Treatment completed: _____
_____
Any history of sedation/attempted sedation? ☐ Yes ☐ No

Radiographs

☐ None Available
☐ Mailed/Emailed Date Taken: _____
☐ Given to patient Date Taken: _____

Upon completion of treatment, please have patient return to our office (referring office) for recalls ☐ Yes ☐ No

Dental Insurance

Primary

Insurance Company: _____
Subscriber Name: _____
DOB: _____
Relationship to Patient: _____
Group/Policy #: _____
ID/Certificate #: _____

Secondary

Insurance Company: _____
Subscriber Name: _____
DOB: _____
Relationship to Patient: _____
Group/Policy #: _____
ID/Certificate #: _____

Please email completed referral form along with radiographs and treatment plan to reception@courtsidedental.ca