Medicine Hat
PEDIATRIC DENTISTRY

**Dr. James Lipon**
DDS, FRCD(C)
Pediatric Dentist

**Dr. John Mansour**
DDS, FRCD(C)
Pediatric Dentist

**Dr. Benjamin Hughes**
DDS, FRCD(C)
Pediatric Dentist

## Patient Information

Today's Date:

Patient Name: Date of Birth: Age: Gender: M/F

Parent/Guardian Name:

Contact Home Address: City/Province: Postal Code:

Contact Telephone: Alternative Telephone:

Permission to text: Yes/No Contact E-mail Address:

## Referring Doctor Information

Referred By: Telephone:

Office Name: E-mail Address:

○ Send more referral pads please

## Pediatric Dentistry

Please list all Caries/Please indicate reason for referral

## Radiographs

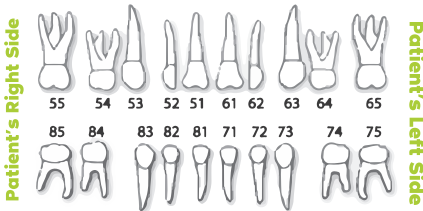
○ E-mailed ○ Given to Patient
○ No X-ray ○ Please Take
○ Mailed

If X-rays are attached, what date were they taken?

## ○ Extractions

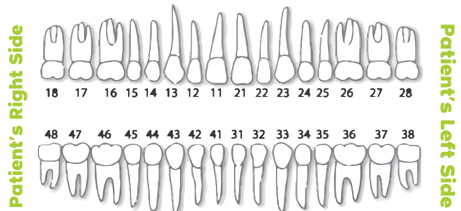
**MARK ANY TEETH TO BE EXTRACTED WITH AN X**

Patient's Right Side




Patient's Left Side

Patient's Right Side




Patient's Left Side

Please verify teeth for extraction:

## Insurance information/Additional Comments

○ Private Insurance ○ ADSC ○ Other (explain)
○ No Insurance ○ NIHB

Company: Policy Holder: Date of Birth:

Group/Plan #: Certificate #: ○ This patient has secondary insurance

Signature of Referring Doctor/Clinic Name:______________________________

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