

Crestmont Dental Sedation Dentistry Referral



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Calgary, Alberta T3B 6K2

Phone: (403) 300-3330
E-mail: crestmont@trecedental.com
crestmontdental.com

Thank you for referring your patient to us at **Crestmont Dental** for sedation dentistry. All procedures are performed by a general dentist.

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____

Gender: Male Female Other

Email: _____

Phone: (Home) _____ (Cell) _____

Guardian Name (if applicable): _____

RADIOGRAPHS

- Radiographs **with patient**
- Radiographs mailed to Crestmont Dental **via courier**
- Radiographs emailed to **crestmont@trecedental.com**

REFERRAL DETAILS:

- One time treatment
- Comprehensive ongoing treatment

Is the treatment plan available? Yes No

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Relevant medical/dental history:

Additional comments/reason for referral:

REFERRING DOCTOR

Doctor's Name: _____ Office Name: _____

Office Number: _____ Office Email: _____