# DR. DARREN DAHLMAN
## DMD, FRCD (C)

*Oral & Maxillofacial Surgeon*

FRASER VALLEY **DENTAL SPECIALISTS**


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**E: specialists@fvdental.ca**


## WE ARE REFERRING

Patient ______________________ Birth Date ______________

Address ______________________ City ______________ PC __________

Email ______________________________________________

Tel. Res. ______________ Cell. ______________ Bus. ______________

☐ Patient will call ☐ Please take radiograph ☐ Radiograph emailed

☐ Appointment is scheduled: ☐ Radiographs being sent ☐ Date radiograph taken:

______________ ☐ Radiographs enclosed ______________

## REASON FOR REFERRAL

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 55 | 54 | 53 | 52 | 51 | 61 | 62 | 63 | 64 | 65 | | | |
| 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 |
| | | | 85 | 84 | 83 | 82 | 81 | 71 | 72 | 73 | 74 | 75 | | | |

☐ Extraction ☐ Pathology / Biopsy ☐ Bone Grafting

☐ Expose & Bond ☐ Implant Consultation ☐ Conebeam CT Scan

Comments ______________________________________________

Referred by Dr. ______________________ Date ______________

## IF PATIENT IS A MINOR

Father's Name ______________________ Mother's Name ______________________

Work or Cell Phone __________________ Work or Cell Phone __________________

## DENTAL INSURANCE

Policy Handler's First Name __________________ Last Name __________________

Employer ________________________________ Date of Birth __________________

Insurance Company Name __________________ Group Policy # __________________

Certificate / ID # ______________ Plan % ________ Dependant # ______________

## SECONDARY DENTAL PLAN

Policy Handler's First Name __________________ Last Name __________________

Employer ________________________________ Date of Birth __________________

Insurance Company Name __________________ Group Policy # __________________

Certificate / ID # ______________ Plan % ________ Dependant # ______________