PRINCE ALBERT SMILES DENTAL CENTRE

Dr. Robin Slowenko Dr. Jason Kopchynski Dr. Steven Arcand

IV SEDATION REFERRAL FORM

PATIENT NAME: _____ **DOB (DD/MM/YYYY):** _____

ADDRESS: _____

_____

EMAIL ADDRESS: _____@_____

PHONE NUMBERS: Home: _____ Work: _____ Cell: _____

INSURED BY: _____ (include Insurance Carrier, Group number and ID number)

*Please note: A Consultation is required before proceeding with any treatment. The Consultation Fee of $119.00 must be prepaid before the Consultation Appointment is scheduled. This may or may not be reimbursed by the patient's insurance provider.

TREATMENT REQUESTED: Please enclose complete treatment plan including radiographs and photos (any referrals sent without this information will be returned)

Current Medical Conditions: _____

Allergies: _____

List of Medications & Dosages: _____

_____

_____

Level of Anxiety: Mild Moderate Severe

Referring Clinic/Doctor: _____ Phone Number: _____

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Cornerstone 720 – 800 - 15th Street East Prince Albert, SK S6V 8E3 T:306.764.4144 F:306.764.5438
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