Medicine Hat
Oral Surgery and Pediatric Dentistry

○ **Dr. James Lipon** DDS, FRCD(C) Pediatric Dentist
○ **Dr. Abe Khaleghi** Bsc, DMD, OMFS, ABOMS Oral Surgeon
○ **Dr. Ali Arsalan** DDS, MSD, FRCD(C) Pediatric Dentist

○ Send more referral pads please

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:

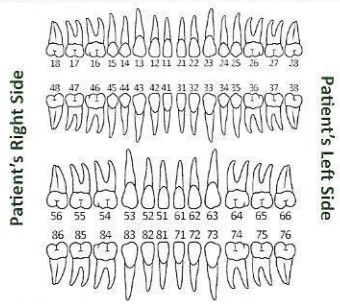
● Pediatric | Oral Surgery ●

Please list all Caries/extractions/reason for referral:

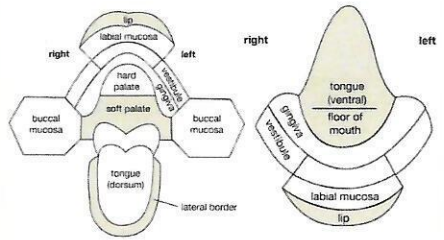
Radiographs

X-Rays have been: E-mailed Not Yet Taken If X-rays are attached, what date were they taken? _____

Odontogram: Place an "X" through teeth to be removed



Pathology: Place an "X" on the area of concern



Additional Information:

Insurance Information / Additional Comments

○ Private Insurance ○ ADSC ○ Other (explain) _____
○ Jordan's Principle ○ NIHB
○ No Insurance

Company: Policy Holder: Date of Birth:

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

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