Dr. Dove
DENTAL OFFICE

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☐ **Dr. Michael Dove, HBSc, DDS, MaCDS**
☐ **Dr. Sabina Shin, BSc, MSc, DMD**

Referring Doctor: _____ Office phone: _____

Patient Information

Name:_____ Date of Birth: _____

Address:_____

Phone:_____

Reason for Referral

☐ Restorative
☐ Crown/Bridge/Veneers
☐ Endodontics
☐ Extraction/Wisdom teeth
☐ Implants
☐ Implant-supported dentures
☐ Difficulty with local anaesthetic?
☐ Anxiety/High gag reflex?

Sedation

☐ Yes, which one ☐ No

☐ Conscious sedation (N2O, oral/N2O, IV)

☐ General Anesthesia (Suitable candidates: ASA I or II, see link for further information https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system)
NOTE: we do not treat social services under GA at this time

Treatment overview

_____
_____
_____
_____
_____

Medical history

_____
_____
_____
_____
_____

☐ Appointment booked _____
☐ Patient to call
☐ Call patient
☐ Radiographs ☐ Emailed ☐ Faxed ☐ Enclosed ☐ With patient ☐ None