

Dr. Steve Johal D.M.D., F.R.C.D.(C), CERT. ENDO Certified Specialist in Endodontics T 604-572-9863 • F 604-572-5063

Introducing ____

Tel

For endodontic consideration of the following tooth (teeth):

Reason for referral:

- Consultation only
- Consultation and endodontic treatment
- Patient has discomfort / pain
- O Pulp exposed
- O Root canal started
- Recent dental treatment
- Apical radiolucency present
- Previous root canal treatment
- O _____ month(s) ago _____ year(s) ago

O permanent

- Prophylactic root canal treatment required
- Bridge/crown cemented:
 temporary
- Post space required
- Restore access cavity with:
 temporary
 permanent
- Remarks



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Remarks

Signed Dr. _

Tel_

- Please fill out insurance information on the back of this form
- Please send referral pad

PLEASE FAX OR MAIL TOP PORTION



Patient Appointment

Date		

Time _

Nicholson Centre 103-6900 Nicholson Rd. North Delta, BC V4E 3G5





Signed Dr. ___

Tel ____

 Please fill out insurance information on the back of this form

Please send referral pad

PLEASE FAX OR MAIL TOP PORTION





Date	

Time _____

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103-6900 Nicholson Rd. North Delta, BC V4E 3G5



Dr. Steve Johal

	DENIAL INSURANCE INFORMATION	IION
Name of Policy Holder		Birthdate Day Month Year
Employer	S.I.N.	
Ins. Co	ID #	Dep #
Group/Plan #	Cert #	Div #
% Basic Coverge	Annu	Annual Limit
Relationship to Policy Holder		
Second Insurance Plan		
Name of Policy Holder		Birthdate Day Month Year
Employer	S.I.N.	boy month tow
Ins. Co	ID #	Dep #
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% Basic Coverge	Annu	Annual Limit
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Name of Policy Holder		Birthdate
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