LAKERIDGE DENTAL CENTRE

16 Brock Street West
Oshawa, Ontario
T: 905.725.3511 F: 905.725.5008
Email: info@Ldcteam.ca

Dr. H. S. Bedi, DMD *GENERAL DENTIST*
Dr. Kevin Baweja, DDS *ENDODONTIST*
Dr. Jeff Li, DMD *PERIODONTIST*

REFERRING DOCTOR: _____

DATE: _____ PHONE: _____

OFFICE EMAIL ADDRESS: _____
best email address to send CBCT results to

PATIENT NAME: _____

DOB: _____ BEST PHONE NUMBER: _____

ADDRESS: _____

EMAIL: _____

____CONSULTATION
____EXTRACTION
____IMPLANT SURGERY
____ROOT CANAL THERAPY
____PERIO. TREATMENT
____CBCT RADIOGRAPH
____OTHER:

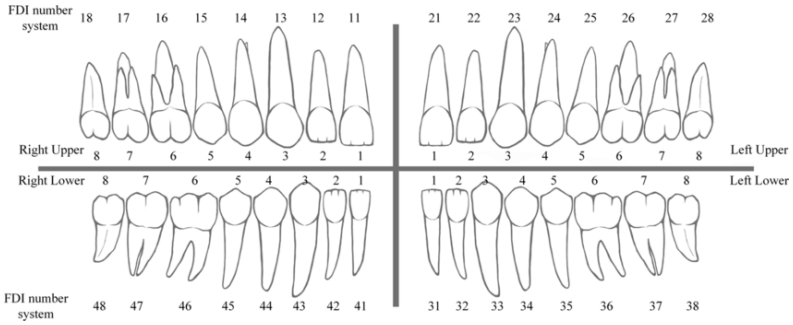
TOOTH NUMBER: _____

SPECIFIC COMMENTS: _____

_____

X-RAYS: ____WILL SEND ____PLEASE TAKE

____PATIENT WILL CALL TO SCHEDULE
____PLEASE CONTACT PATIENT TO SCHEDULE



For Office Use:

Patient Appointment Date: _____

CBCT Read: _____

Report and letter sent back to referring office: _____

Signature: _____