Emerald Hills
DENTAL CENTRE
#170 8005 Emerald Drive.
Sherwood Park, AB T8H 0P1

REFERRAL FOR SURGICAL OR PERIODONTAL PROCEDURES

Patient's Name: _____ DOB: _____
Address: _____
Phone (Res): _____ (Cell): _____

Insurance Company: _____ Plan #: _____
Policy Holder: _____ ID #: _____
Policy Holder DOB: _____

Dr. Pawan Nyachhyon

REFERRED FOR:
__Surgical Extractions: _____
__Implants: _____
__Sinus Lift/Repair: _____
__Bone Grafting: _____
__Apicoectomy: _____
__Cyst Removal: _____
__Surgical Exposure of Crowns: _____

XRAYS:
__BW's __Emailed
__PAN __Mailed
__PA's __Patient bringing

REFERRED BY:
DR._____
Phone: _____

We will contact your patient directly to arrange an appointment. **After treatment is performed, patient will return to your office for post-care.**

This form can be forwarded by either **Fax (587-269-4901**) or **Email** (**Emeraldswp@gmail.com**).

If you require further information, please do not hesitate to contact us at **587-269-4900**.