ROSS McLEAN
DMD, MSD Endo, FRCDC

Kamloops Endodontics

Certified Specialist in Endodontics
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A: WE ARE REFERRING:

Patient: _____ M / F Birthdate: (D/M/Y) _____

Address: _____ Postal Code: _____

City: _____ Email: _____

Telephone: Res: _____ Work: _____ Cell: _____

Has this patient previously been seen in our office? _____

To see: ❑ Dr. Ross McLean ❑ Associate ❑ First Available

DENTAL INSURANCE INFORMATION: (*Please advise your patients,* we DO NOT accept assignment)

Insurance Carrier: _____ Insured: _____

Group Policy No.: _____ ID/SIN: _____ Cert: _____

Employer: _____ Insured's DOB: _____

Basic %: _____ C&B%: _____ Dependant # _____

Secondary Carrier: _____ Insured: _____

Group Policy No.: _____ ID/SIN: _____ Cert: _____

Employer: _____ Insured's DOB: _____

Basic %: _____ C&B%: _____ Dependant # _____

B: REASON FOR REFERRAL:

- **Consultation:** _____
- **Treatment:** _____
- **Relevant History (medical & dental):** _____

C: REFERRING DENTIST:

- **Name & Phone #:** _____
- **Tooth number:** _____
- **SPECIAL NOTES:** _____

CT Scan: 3-D cone Beam Computed Tomography

❑ **Single Tooth #** _____

❑ **Single Sextant #** _____

❑ **Multiple Teeth #** _____

Signed Dr. _____

❍ APT Booked _____ ❍ Copy of referral faxed _____

❍ Crown temp cemented ❍ Crown perm cemented

❍ Leave post space ❍ Please leave temporary filling

❍ X-Rays enclosed ❍ X-Rays emailed _____

OFFICE STAMP