Kootenay
Dental Arts
Family Dentistry & Implant Centre

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SCAN REFERRAL

Date: _____

Patient: _____ D.O.B.: _____

Address: _____

Contact Number: _____

Please provide image of the following area _____

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

Notes _____

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Referring Dentist