250-862-3070
INFO@BURTCHDENTAL.COM
#9-1455 HARVEY AVENUE
KELOWNA BC V1Y 6E9

REFERRAL TO
-DR. KRIS KAHLS–
General Dentist: Practice Limited to Oral Surgery

WE ARE REFERRING:

Patient_____ Guardian_____ Date of Birth_____
Address_____ Postal Code_____
Telephone:_____ Cell_____ Email_____

INSURANCE INFORMATION
Insurance Company_____
Insured Name_____
Insured Birthdate_____
Employer_____
Group No._____
I.D. No._____
Basic Coverage_____%

REASON FOR REFERRAL_____

RELEVANT HISTORY – (medical alerts-allergies-special factors relevant to diagnosis and treatment)
_____

Circle Teeth to be Extracted

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

Please Email a Panorex if taken within the last year to admin@burtchdental.com
Is Patient Interested in Sedation – Y or N

REFERRED BY DOCTOR_____ PHONE_____ DATE_____

EMAIL OF REFERRING DENTAL OFFICE_____