

Dr. Choo-Soon Kua

DDS, FRCDC

Certified Specialist in Oral and Maxillofacial Surgery

Patient Information:

Name: _____

Date of Birth (DD/MM/YYYY): _____

Email: _____

Phone: _____

Reason for Referral (select all that apply):

Extractions: |

8 7 6 5 4 3 2 1 | **1 2 3 4 5 6 7 8**

|

Implants/bone grafting (specify site): _____

Pathology (specify area): _____

Other: _____

Comments:

Referring Doctor Information:

Dr.: _____

Referring Office: _____

Email: _____

Phone: _____



5216, 7005 Fairmount Drive SE
Calgary, AB T2H 0K4