



**ST. ALBERT
ENDODONTICS**
DR. KEN DICK

15 Carleton Drive, #102
St. Albert, Alberta T8N 7K9

Endodontist

K. R. Dick*, D.M.D., F.R.C.D. (C)

*Professional Corporation

REFERRAL

Introducing:

Previous Patient _____ D.O.B.: _____
 Address: _____ P.C.: _____
 PH: (780) **544-0599**
 FX: (780) 418-4005
 W: stalbertendo.com
 E: info@stalbertendo.com

Email:

Ph (Res): _____ Ph (Bus): _____ Ph (Cell): _____
 Appointment Date and Time: _____

Patient's Insurance Company:

Group/Plan#: _____ Cert.#/ID#: _____

Secondary Insurance Company:

Group/Plan#: _____ Cert.#/ID#: _____
 Employee: _____ D.O.B.: _____

Referred For:

Consultation Re: Tooth/Teeth: _____ Area: _____
 Endodontic Treatment for Tooth/Teeth: _____ Area: _____
 Conventional Retreatment Surgical Post Space: Yes No

Relevant History:

Additional Considerations: (allergies, anxiety/oral sedation, prophylactic antibiotics)

Referred by Dr. _____ Date: _____

Please send additional referral forms

Patients can log onto our secure website at www.stalbertendo.com and conveniently complete Patient Registration, Medical history and Pain history online prior to the appointment.

Please contact our office for an ID and Password: info@stalbertendo.com

PLEASE SEE REVERSE FOR LOCATION MAP AND PARKING INFORMATION



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