Dentrix DentalCare

Dr. Alok Singh B.Sc.,DDS
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Patient name: ____

DOB: ______________________ Phone number: ______________________

Date: ______________________

Please check off: ☐ IV sedation ☐ Oral Sedation ☐ CT Scan

Extractions required (please circle)

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

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

Planned Treatment

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Additional Notes

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Current Radiographs: ☐ Sent with Patient ☐ Mailed ☐ E-mailed ☐ Attached ☐ No Current

Referring Doctor: ____

Phone Number: ____

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Fax 403-284-2584

****We are located in NorthHill Mall on the main level inside entrance #3, next to Pearl Vision.****