



Dr. Mohamed Soliman BDS, DOS, 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

Additional Notes

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.****