



ORAL MEDICINE

Dr. Allan Hovan

Certified Specialist

DATE OF REFERRAL:

PATIENT NAME:

PATIENT PHONE #:

PATIENT EMAIL:

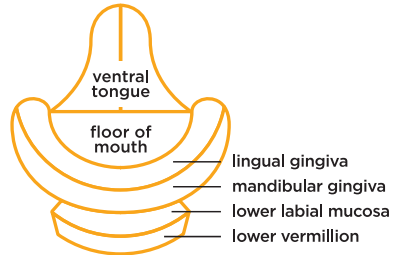
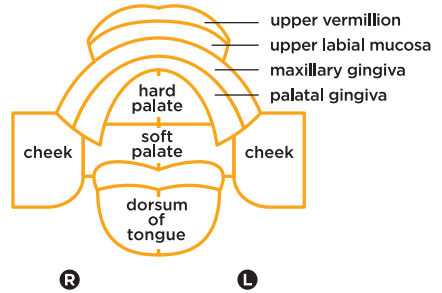
REFERRED BY DR.:

DR. PHONE #:

TOOTH/AREA OF CONCERN

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



IMAGES

- X-rays
- Photos → Emailed
- Mailed
- Available
- Not available, take as needed

REFERRAL REQUEST

- Oral Mucosal Disorder / Pathology
- Temporomandibular Disorder / Jaw Dysfunction
- Orofacial Pain
- Oral Manifestation of Systemic Disease



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