

New West Oral Surgery

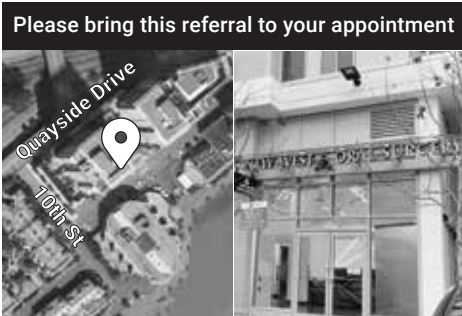
Certified Specialists Oral & Maxillofacial Surgery

Dr. Ray Grewal · Dr. Akash Villing · Dr. Harsh Mangat

982 Quayside Dr, **Phone** (604) 553-6725
 New Westminster, BC **Fax** (604) 553-6727
 V3M 0L5 **Email** info@newwestoralsurgery.com

To assist your patients, we accept most insurance plans on an assignment basis. We place great emphasis in providing quality care to patients in need. As such, emergency patients are met with our utmost priority and will be treated on the same day.

*Your appointment is reserved specifically for you. If by necessity you must **cancel your appointment for surgery, please notify us at least two days in advance.***



Patient		Reason for Referral <input type="checkbox"/> 3rd Molar <input type="checkbox"/> Extractions <input type="checkbox"/> Implants <input type="checkbox"/> Augmentation <input type="checkbox"/> Sinus Lift <input type="checkbox"/> Socket Graft <input type="checkbox"/> Ridge <input type="checkbox"/> Botox <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> Jaw Fracture / Trauma <input type="checkbox"/> Alveoplasty <input type="checkbox"/> Apicoectomy <input type="checkbox"/> Expose & Bond <input type="checkbox"/> Frenectomy <input type="checkbox"/> Infection <input type="checkbox"/> Lesion <input type="checkbox"/> TMJ <input type="checkbox"/> Orthognathic <input type="checkbox"/> Other _____	Please indicate teeth to be removed or surgery to be performed	
Birth Date	Guardian <small>(if applicable)</small>		18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28 48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38	
Patient Phone	Patient Address		R 55 54 53 52 51 61 62 63 64 65 L 85 84 83 82 81 71 72 73 74 75	
Referred by	CITY _____ POSTAL CODE _____		Comments 	
Date referred	Dental Insurance Information			
Referral Phone	Plan Name: _____ Policy No: _____ ID No: _____ Dependent No: _____ Insured Name: _____ Insured DOB: _____ Basic Percentage: _____ Annual Maximum: _____			
<input type="checkbox"/> Please take Radiograph <input type="checkbox"/> Radiograph enclosed <input type="checkbox"/> Radiograph given to patient				