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Dr. Brian Lam DMD, FRCD(C)*
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Dr. Darren Isfeld DMD, FRCD(C)*

** Registered Specialist in Pediatric Dentistry*

Referring Dr: _____	Date: _____ DD/MM/YY
Email: _____	Phone: _____

Patient Name: _____ DOB: _____
DD/MM/YY

Address: _____ Post Code: _____

Contact Name: _____ Phone: _____

Email: _____

- Consult/Treatment Emergency Care Special Needs
 General Anesthesia Requires Continual Care

Notes: _____

Radiographs are: Enclosed Emailed With Patient
 Mailed Separately None Date Taken: _____
DD/MM/YY

Insurance Information: ADSC NIHB Private None
 Our practice requires more referral pads

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