Little Dreamers Dentistry
for dentistry asleep...

www.littledreamersdentistry.com

DATE: _____

PATIENT NAME: _____

AGE: _____ PHONE #: _____

Referral for Complete Treatment ☐

Referral for Specific Treatment ☐

_____

_____

_____

Radiographs included:

☐ E-Mailed ☐ Sent with Patient

☐ None Taken ☐ Please Take

Referring Office/Dentist: _____

Address: _____

Phone: _____

Email: _____

☐ Check to receive follow-up letter by email.

All patients will be returned to your clinic for regular dental care

30 Innovator Avenue, Unit 3
Stouffville, ON L4A 0Y2

✉ info@lddentistry.ca
☎ **905-591-7999**
905-591-7990

Our office accepts Healthy Smiles (HSO)

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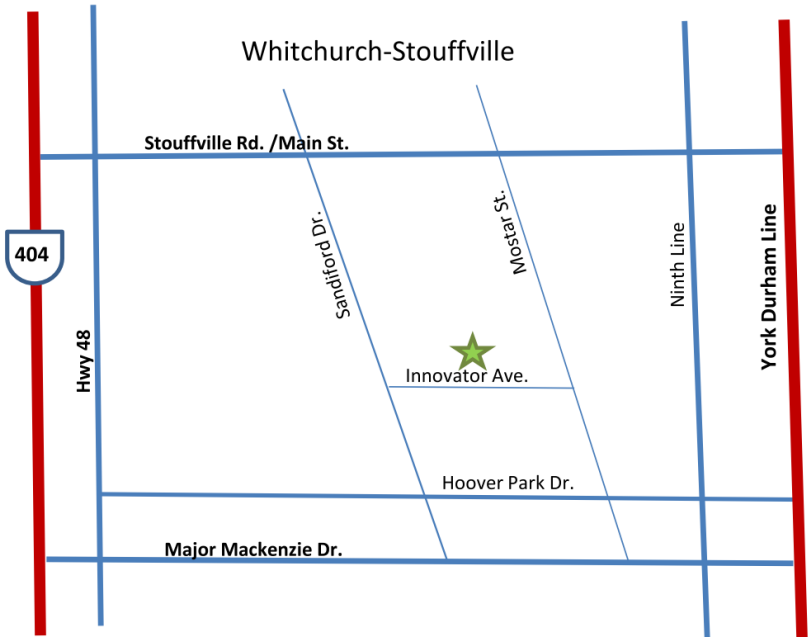

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