



Where Kids Come First

Dr. Charles Lekic
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Patient Information

Name of Patient: _____

DOB (Y.M.D): _____

Patient Phone #: _____

Parent/Guardian: _____

Referring Dentists: _____

Date of Referral: _____

Dentist Phone #: _____

Referring for Pediatric Dentistry

Dr. C. Lekic Dr. C. Yue 1st Available

This is an emergency referral regarding:

Trauma Pain Swelling

General Anesthetic

This is a non - emergency referral regarding:

Please call the patient/parent/guardian to arrange appointment Yes No

We are sending the most current radiographs Yes No

Upon completion of treatment please have patient return to our office for recall appointments Yes No

Insurance Information

Subscriber Name _____

DOB (Y.M.D): _____

Insurance Company _____

Group/Policy # _____

ID # _____

Referring for Orthodontic Dentistry

Dr. M. Lekic

Please evaluate for: _____

Comprehensive Orthodontic Treatment

Early Treatment / Growth Modification