



REGINA

Where Kids Come First

Dr. Charles Lekic
Dr. Christopher Yue
Dr. Milos 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

Please send me a follow up report upon completion of all treatment

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

Yes No

Yes No

Yes No

Yes No