**West End Medical Professional Building**
**M1, 9509 – 156 Street**
**Edmonton, Alberta, T5P 4J5**
780-487-9192
info@naturalchoicedentures.com

**Michael K. Weiss BSc, DD**
**Sarah K. Weiss RDA, DD**
**Mason L. Weiss DD**

Date: ____________________

Patient Name: ____________________________________________________________________________

Address: ________________________________________________________________________________

Phone: __________________________________________

Alberta Health Care: _____________________________ D.O.B: ____________________________

Insurance: ________________________________________________________________________________

**REASON FOR REFERRAL:**

- ☐ Complete Dentures
- ☐ Immediate Dentures
- ☐ Partial Dentures
- ☐ Implant Retained Dentures
- ☐ Other _____________________

Comments / Additional Information:

______________________________________________________________________________________

______________________________________________________________________________________

Teeth to be extracted (please circle):

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

**Has all restorative work been completed? Yes / No**

Referring Doctor: _____________________________ Phone: ___________________________