



**PDG**  
Pediatric Dentistry &  
Orthodontics

**Certified Specialists in Pediatric Dentistry**

**Donald W. Scheideman**, DMD, Dips Peds, FRCDC  
**Anabel R. Chan**, DDS, Dip Peds, MSc, MRCDC  
**M-Reza Nouri**, DMD, Dip Peds, MSc, FRCDC  
**Louisa Y. Leung**, DMD, Dip Peds, MS, FRCDC  
**Carter K. Ng**, DDS, Dip Peds, MSc, FRCDC  
**Bradford W. Scheideman**, DMD, Dip Peds, FRCDC  
**Janice Duong**, DMD, MSc, Dip Peds, FRCDC

**Certified Specialists in Orthodontics**

**Donal C. Flanagan**, DDS, MS, FRCDC  
**Christian A. Wong**, DDS, MS, FRCDC  
**Todd R. Moore**, DDS, Msc, FRCDC

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB (m/d/y): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Guardian's name: \_\_\_\_\_ Email: \_\_\_\_\_

**REFERRING DOCTOR INFORMATION**

Referring Doctor: \_\_\_\_\_ Practice Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**REFERRING TO PEDIATRIC DENTISTRY**

- |   |  |  |
|---|--|--|
| <input type="radio"/> Pain                  | <input type="radio"/> X-rays Panographic | <input type="radio"/> General Anaesthetic          |
| <input type="radio"/> Anxiety               | <input type="radio"/> X-rays Bitewings   | <input type="radio"/> Restorative Work Required    |
| <input type="radio"/> Medical Concerns      | <input type="radio"/> X-rays Periapicals | <input type="radio"/> Previous Negative Experience |
| <input type="radio"/> Specific Problem Only | <input type="radio"/> Other: _____       |  |

**REFERRING TO ORTHODONTICS**

- |                                 |                                 |                                     |   |
|---------------------------------|---------------------------------|-------------------------------------|---|
| <input type="radio"/> Crowding  | <input type="radio"/> Spacing   | <input type="radio"/> Missing Teeth | <input type="radio"/> Facial            |
| <input type="radio"/> Overjet   | <input type="radio"/> Overbite  | <input type="radio"/> Extra Teeth   | <input type="radio"/> Symmetry          |
| <input type="radio"/> Class II  | <input type="radio"/> Openbite  | <input type="radio"/> Habit         | <input type="radio"/> Eruption Problems |
| <input type="radio"/> Class III | <input type="radio"/> Crossbite | <input type="radio"/> Other: _____  |   |

NOTES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE FORWARD RADIOGRAPH PRIOR TO APPOINTMENT**

- X-rays included     Please call me  
 X-rays emailed     Please call patient

*Thank you for your referral.  
 We appreciate your trust in allowing us to be part of your patient's dental care!*

**Vancouver**  
 #200 - 650 West 41st Ave.  
 Vancouver, BC V5Z 2M9

**Richmond**  
 #230 - 6180 Blundell Rd.  
 Richmond, BC V7C 4W7

**Delta**  
 #107 - 6345 120th St.  
 Delta, BC V4E 2A6

**Coquitlam**  
 #101 - 2973 Glen Dr.  
 Coquitlam, BC V3B 2P7

**604-PDG-1000**  
**(604-734-1000)**

[www.PDGdental.com](http://www.PDGdental.com) / [contactus@pdgdental.com](mailto:contactus@pdgdental.com)