



#65 – 1967 East Trans Canada Hwy
Kamloops, BC V2C 4A4
Phone: 250.374.2615
www.smilekamloops.com

Date: _____

We are referring:

Name: _____ Birthdate: _____

Address: _____

Phone (H): _____ (Cell): _____ Work: _____

Email: _____

Referral Reason:

Special Considerations:

Insurance Information:

Primary Carrier: _____ Policy #: _____ ID#: _____

Secondary Carrier: _____ Policy #: _____ ID#: _____

Spouse name: _____ Birthdate: _____

Radiographs: ☐ Enclosed ☐ Take new radiographs ☐ Emailed

Appointment: ☐ Patient will call ☐ Please call patient

Referred by:

Dr. _____ Telephone: _____

Email: _____

Please send this form by email to info@smilekamloops.com or by fax to 250.374.2645.