



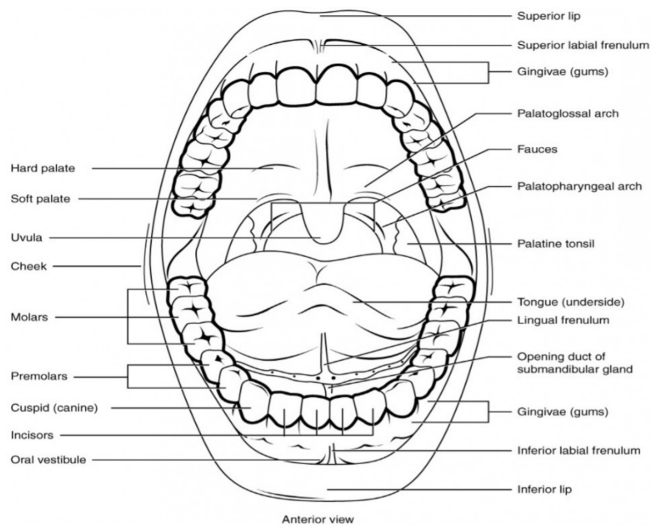
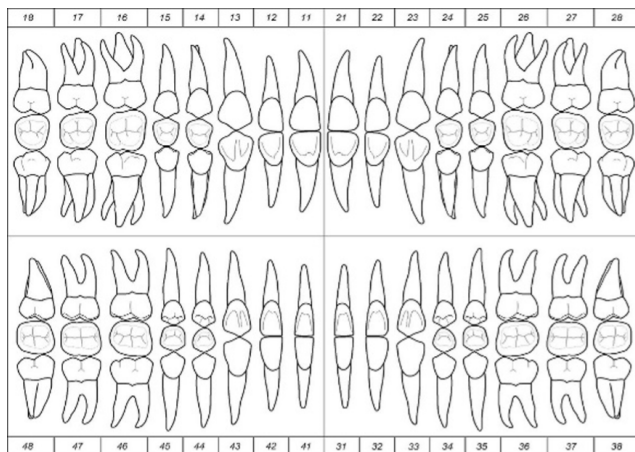
GRANDVIEW CORNERS DENTAL REFERRAL

REFERRING DOCTOR: _____

DATE: _____

PATIENT NAME: _____

TEL/CEL: _____



TREATMENT NEEDED:

- ☐ CROWN ☐ BRIDGE ☐ RESTO
☐ ENDO ☐ INVIS ☐ BOTOX
☐ IMPLANTS ☐ OTHER

DENTIST:

- ☐ DR. CHANDAN JASPAL ☐ DR. OWAIS IQBAL ☐ DR. JENNY JOHAL
☐ DR. NAJWAN STEPHAN-TOZY ☐ DR. KEVAL PATEL