www.treehousedentalcare.ca

info@treehousedentalcare.ca

Treehouse
Dental Care

Date: _____

Introducing: _____

Phone # (Res): _____ Age: _____

X-Rays:

☐ Emailed ☐ Mailed ☐ To Be Taken ☐ With Patient

Referral For: _____

☐ Please provide complete care ☐ Consult (specify)

☐ Treatment requested (specify) ☐ Sedation (specify)

Treatment Plan: _____

_____

Referring Professional: _____

Phone #: _____

Email: _____

Please provide treatment report by: ☐ Email ☐ Mail

☐ ETOBICOKE
Etobicoke Wellness Centre
115 Humber College Blvd., Suite 101
Etobicoke, ON T: 416.740.4016

☐ THORNHILL
1 Promenade Circle, Suite 301K
Health Court, 3rd Floor
Thornhill, ON T: 905.882.9888

☐ TORONTO
1560 Yonge Street, Suite 290
Toronto, ON T: 416.922.2668