ADVANCED PEDIATRIC DENTISTRY

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Date: _____

Introducing: _____

Parent/Patient Concerns: _____

_____

_____

Please evaluate for:

- ☐ Dental caries/cavities
- ☐ Trauma/emergency
- ☐ Sedation/general anesthesia
- ☐ Other

Comments: _____

_____

_____

_____

Radiographs

- ☐ Parents will bring
- ☐ Please take if needed
- ☐ Will be mailed
- ☐ Will send electronically

Referred by Doctor _____

Office: _____

Office Number: _____