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Diplomate, American Board of Pediatric Dentistry

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Date _____

Referred by Dr. _____

Patient _____

Patient Phone # _____

Reason for referral (Specify below)

- ☐ Emergency Treatment
- ☐ Comprehensive care
- ☐ Restorative
- ☐ Other

Remarks

_____

_____

_____

- ☐ Please return patient to referring office after tx is completed
- ☐ Please accept as a new patient
- ☐ Evaluation Only
- ☐ Please call me before proceeding with treatment

Prior tx or significant dental history

_____

_____

Medical History

_____

_____

Were radiographs obtained?

- ☐ Yes, included
- ☐ Yes, please contact our office _____
- ☐ No

NOTES

Please bring referral note with you to appointment.
Minors must be accompanied by parent or guardian.