CHILDREN'S DENTAL CARE

www.childrensdentalcaremi.com

Referral Date: _____

Patient Name: _____ **Patient Age:** _____

Referring Doctor: _____ **Referring Doctor Tel #:** _____

Reason for Referral

- ❑ 1st Dental Visit
- ❑ Trauma
- ❑ Space Maintainer
- ❑ Extensive Decay
- ❑ Special Needs
- ❑ Nitrous Oxide
- ❑ Toothache
- ❑ Sedation
- ❑ Extraction
- ❑ General Anesthesia

Dental Radiographs

- ❑ None Available
- ❑ X-rays - Please give to patient/Email

Remarks: _____

_____

NO TREATMENT WILL PERFORMED AT THE 1ST VISIT (CONSULTATION ONLY)