REFERRAL TO AMERICAN CANYON PEDIATRIC DENTISTRY

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PEDIATRIC DENTISTRY

"WHERE EVERY KID IS A STAR!"

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INTRODUCING MY PATIENT: _____

PATIENT DOB: _____

PARENT CONTACT/#: _____

REFERRING DOCTOR: _____ DATE: _____

REFERRING DOCTOR'S PHONE NUMBER: _____

PATIENT NEEDS:

- ❑ TREATMENT WITH SEDATION/GENERAL ANESTHESIA
- ❑ FILLINGS
- ❑ CONSULTATION
- ❑ PROPHY
- ❑ OTHER

RADIOGRAPHS:

ARE NEEDED ❑ SENT BY EMAIL ❑ ACCOMPANYING PATIENT ❑

COMMENTS: _____

_____

❑ PATIENT TO RETURN TO OUR OFFICE FOR ROUTINE EXAMS AND CLEANINGS