



**ADVANCED
PEDIATRIC
DENTISTRY**

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Date: _____

Introducing: _____

Parent/Patient Concerns: _____

Please evaluate for:

Dental caries/cavities

Sedation/general anesthesia

Trauma/emergency

Other

Comments: _____

Radiographs

Parents will bring

Will be mailed

Please take if needed

Will send electronically

Referred by Doctor _____

Office: _____

Office Number: _____