Rockville pediatricdental

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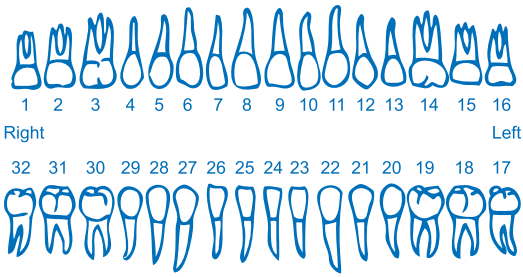
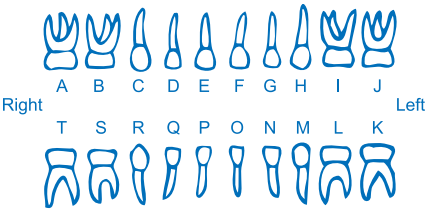
REFERRAL FORM

Patient name: _____ Age: _____

Permanent



Deciduous



Please evaluate for:

- ☐ Emergency: Trauma / Infection
- ☐ Dental care for children with special needs
- ☐ Conscious sedation for extensive cavities
- ☐ Treatment under general anesthesia
- ☐ Tethered Oral Tissue evaluation / Laser Frenectomy
  - ☐ Tongue tie ☐ Maxillary lip-tie ☐ Mandibular lip-tie

Remarks: _____

_____

_____

_____

_____

Radiographs included: ☐ peri-apical ☐ bite-wings ☐ occlusal ☐ panoramic

Doctor: _____ Date: _____

Address: _____ Phone: _____