avenue
PEDIATRIC DENTISTRY

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PATIENT INFORMATION

Name _____ Gender ____ Date of birth _____

Address _____

Phone number(s) _____ Email _____

REQUESTED CONSULTATION/TREATMENT

- ❑ Emergency
  - ❑ Trauma
  - ❑ Pain
  - ❑ Infection
- ❑ Specific treatment
- ❑ Comprehensive care

TEETH/AREA

_____

_____

_____

_____

_____

_____

SPECIAL INSTRUCTIONS

- ❑ Behaviour/age
- ❑ Medically compromised/special needs
- ❑ Conscious sedation
- ❑ General anesthesia

COMMENTS

_____

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_____

RADIOGRAPHS

❑ None available ❑ Enclosed ❑ Emailed ❑ Mailed ❑ With family

- ❑ Please call this family to arrange a consultation.
- ❑ This family will call your office to arrange a consultation.
- ❑ Please send more referral pads.

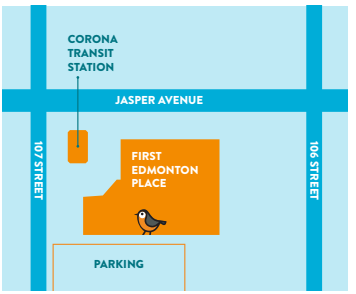
REFERRING PRACTITIONER

Name _____

Phone Number _____

Date _____

WHERE TO FIND US



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