PARKSIDE
PEDIATRIC DENTISTS

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www.parksidepediatricdentists.com

Date

We will be referring _____ to your office for the following dental conditions:
PATIENT'S NAME

_____

_____

_____

_____

PARENT'S NAME _____ PHONE NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

RADIOGRAPHS

- ☐ Radiographs will be emailed
- ☐ Radiographs given to patient
- ☐ No radiographs taken, please take new films

BEHAVIOR MANAGEMENT

- ☐ N2O
- ☐ Sedation with Anesthesiologist

FOLLOW UP

- ☐ Schedule patient for recall appointments
- ☐ Have patient return for hygiene care

LOCATION

- ☐ Antioch
- ☐ Concord
- ☐ Brentwood

REFERRING DOCTOR _____

PHONE NUMBER _____

EMAIL ADDRESS _____

Don Do DDS, MS

Diplomate, American Board of Pediatric Dentistry

Please send this referral with the patient to our office or email to our office.
Thank you for collaborating with us!!