PARKSIDE
PEDIATRIC DENTISTS

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_____
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

FOLLOW UP

- ☐ schedule patient for recall appointments
- ☐ have patient return for hygiene care

_____
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 complete electronically on our website. Thank you for this referral!