



Children's Dental Columbia

James L. Hutton III, D.D.S.
Heather H. Owens, D.D.S.
Gina M. Hanafi, D.M.D.

Patient Name _____ DOB: ___/___/___

Parent/Guardian Name _____ Phone: _____-_____-_____

Patient Insurance TNCARE Other _____

Reason for referral: Please check all that apply

- 1st Visit Age/Behavior Trauma/Emergency/Toothache Restorative Only
- Extractions Oral Sedation Hospital Case IV Sedation Special Needs

The Referring Dr. performed

X-rays that you are sending

Exam Date: _____

Panoramic Date: _____

Prophy Date: _____

BWX Date: _____

Fluoride Date: _____

Periapical Date: _____

	1	2	3	4	5	6	7	8	9		10	11	12	13	14	15	16		
R																			L
	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		

Notes: _____

Referring Doctor: _____ Date: ___/___/___

Doctor requests phone consultation

1706 Wedgewood Drive

Office Hours:

Columbia, TN 38401

Monday-Thursday

Phone: 931-381-9721

8-5pm (Lunch 12-1pm)

Fax: 931-381-3507

Friday 8-12pm

Email: info@ChildrensDentalColumbia.com



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