Children's Dental Associates
PEDIATRIC DENTISTRY

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Patient Name _____ **DOB:** _____

Parent/Guardian Name _____ **Phone**_____

Patient Insured by ☐TNCARE ☐DDTN ☐BCBSTN ☐CIGNA PPO ☐UMR/UHC ☐Other_____

Reason for referral: (Please Check all that apply)

☐ 1st Dental visit ☐ Decay/Caries ☐ Trauma ☐ Oral Sedation

☐ Age/Behavior ☐ Toothache ☐ Anxiety ☐ IV Sedation

☐ Special Needs ☐ Extractions ☐ Emergency ☐ Hospital Case

X-rays that we are sending:

☐ Panoramic Date _____

☐ BWX Date _____

☐ Periapical Date _____

Please evaluate the following teeth (please circle)

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

R L

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

Procedures Performed at your office:

☐ Exam ☐ Fluoride ☐ Sealants

☐ Prophy ☐ X-rays ☐ Other _____

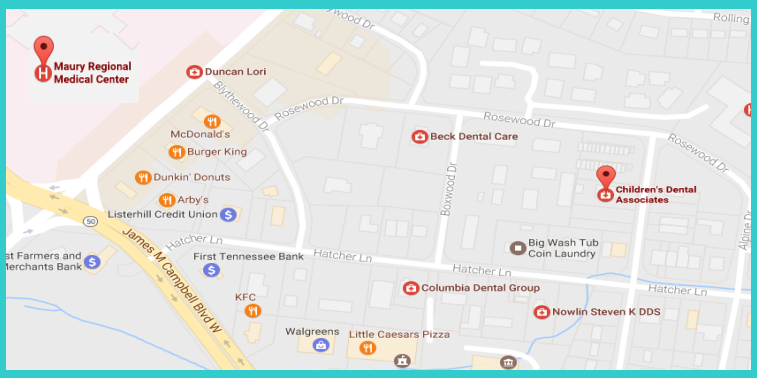
Notes:_____

_____

_____

Referring Doctor:_____ Date _____

☐ Phone Consultation Requested



We look forward to hearing from you!

Office Hours

Monday-Thursday

8am-5pm (lunch 12-1pm)