PEDIATRIC DENTAL CENTER OF Avon

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Introducing Patient: _____ Birthdate: _____/_____/_____

Referring Provider, Phone #: _____

☐ Please Call Patient, Phone #: _____ ☐ Patient Will Call For Appointment

Procedure(s) Requested

☐ 1st Dental Visit
☐ Routine Dental Care
☐ Restorative Treatment of Decay
☐ Oral Rehabilitation under General Anesthesia
☐ Frenectomy
☐ Other: _____

Dental History

Date of Last X-rays: ___/____/____: ☐ BW ☐ Pano ☐ Other: _____

☐ Treatment attempted ☐ Treatment not attempted

Comments:

_____

_____

Please Circle Teeth To Be Treated

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
RIGHT			A	B	C	D	E	F	G	H	I	J			LEFT
			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

Provider's Signature: _____ Date: _____/_____/_____

Please email this referral and any x-rays to mail@pdcofavon.com. Thank you!