

VENETIA *Laganis* DDS,MS

PEDIATRIC DENTISTRY



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To best serve your patients please complete referral in its entirety, Thank you!

Date: _____

Child's Name: _____

Child's Birthdate: _____

Parent's Name: _____

Phone Number: _____

Referring Dentist: _____

Referring Dentist Phone Number: _____

Findings/Comments: _____

Most Recent Dental Exam Date: _____

Most Recent X-rays: _____

Most Recent Prophylaxis: _____

Most Recent Fluoride Application: _____

Treatment Attempted? Yes () No ()

If yes, date and outcome (please include child's behavior): _____