Woodland
PEDIATRIC DENTISTRY
Sheh Vahid, DMD, MS

Referring Doctor: _____ Date: _____

Patient's Name: _____ DOB: _____

RADIOGRAPHS:

☐ Attempted ☐ Not Attempted

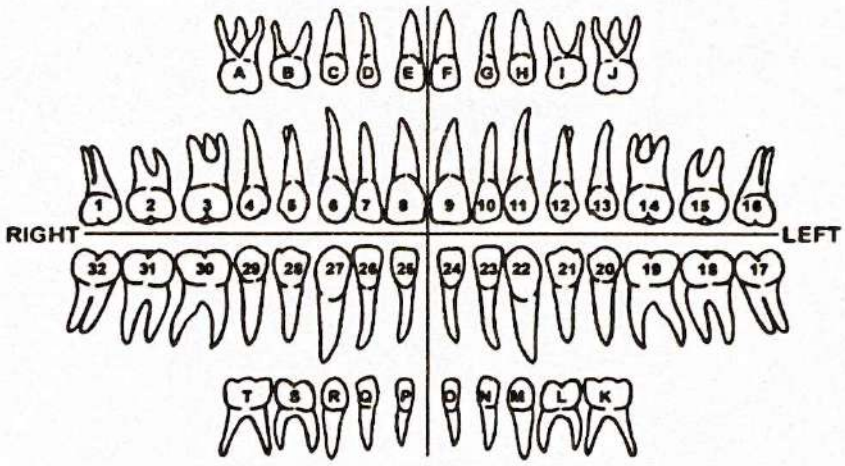
☐ Completed/Date_____ ☐ Sent With Patient

PLEASE EVALUATE FOR:

☐ 1st Dental Visit ☐ Toothache ☐ Decay ☐ Extraction

☐ Special Needs ☐ Trauma ☐ Sedation / Anesthesia

☐ Oral Habits ☐ Orthodontics Evaluation ☐ Other_____



COMMENTS: _____

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_____

PLEASE SEND THIS REFERRAL WITH THE PATIENT OR EMAIL TO OUR OFFICE
(dentistry@woodlandpedo.com)

Thank you for trusting us with your patient's oral health!

P: 678-498-2878 • F: 678-905-1103

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woodlandpedo.com