PLAZA DENTAL PEDIATRICS

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Introducing: _____ Age: _____

Referring Practice: _____

Date of Last Exam: _____ Date of Last Prophy: _____

Date of Last Fluoride Treatment: _____ Date of Last X-rays: _____

X-ray Delivery ☐ Fax/Email ☐ Patient

				a	b	c	d	e	f	g	h	i	j			
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16 **L**
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
				t	s	r	q	p	o	n	m	l	k			

We are referring the patient above for the following reasons:

_____

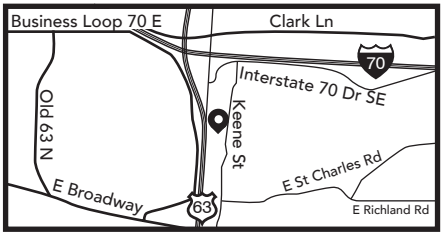
_____

_____

_____
Referring Doctor's Name

_____
Phone Number

most dental insurances accepted



**Thank you for your referral.
We appreciate your trust!**

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