CHILDREN'S DENTAL CENTER OF MADISON, S.C.

Date: _____

Introducing: _____

Parent/Guardian _____Phone: _____

Please mark services you performed:

- ❑ Prophylaxis Date: _____/_____/_____
- ❑ Fluoride
- ❑ Exam
- ❑ Bitewings ❑ Panorex ❑ Periapical
- ❑ Treatment was/was not attempted

If x-rays were taken:

- ❑ They have been mailed
- ❑ Patient will bring
- ❑ Emailed (Note: emails listed below)

Remarks: _____

_____

_____

Referred by Dr.: _____ Phone: _____

Appointment: _____ Time: _____

Initial appointment will be for examination and consultation only.

Your appointment is at the location checked below. Map of locations on backside.

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White Copy - *Patient* Yellow Copy - *CDC* Pink Copy - *Referring Dentist*

Children's Dental Center of Madison

www.MadisonKidsDentist.com