PARKSIDE
pediatric dentistry

MARY W. DOORNBOS, DMD
Diplomate, American Board of Pediatric Dentistry

Date _____

Patient Name _____ Age _____

Referred By _____

Contact Tel. No. _____

Reason for Referral:

❑ 1st Dental Visit ❑ Evaluation for tongue-tie and/or lip-tie

❑ Pain ❑ Dental Trauma

❑ Decay ❑ Dental Treatment with Anesthesiologist

Other _____

Radiographs:

❑ None ❑ X-rays sent with patient ❑ X-rays sent via email

141 Lacy Street, Suite 150 • Marietta, GA 30060
p 770.485.1492 f 770.693.9899 e info@parksidepediatricdentistry.com
www.parksidepediatricdentistry.com