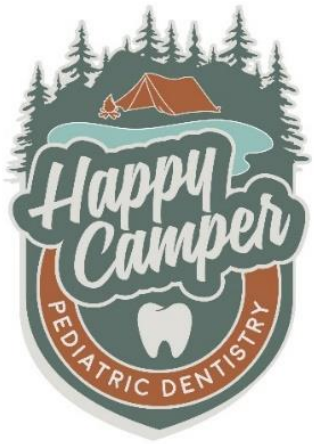

Date _____

Introducing _____ DOB _____

Guardian Name _____ Phone _____

Referring Office/Doctor _____

Reason for Referral:

- ☐ First dental visit
- ☐ Decay
- ☐ Trauma
- ☐ Sedation/ General anesthesia
- ☐ Significant medical history
- ☐ Other _____

_____

- ☐ Treatment has been attempted.
- ☐ Treatment has not been attempted.
- ☐ Radiographs emailed to office.
- ☐ No radiographs available.

Thank you for your referral!

Chris Goodell, DMD

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