Southern Smiles

pediatric dentistry

1512 NC 24-87, Cameron, NC 28326
info@southernsmileskids.com
910-947-5433

Patient name: _____ Age: _____

Phone(s): _____

Parent's name: _____

Special health concerns_____

Reason for referral:

- ❑ Caries/decay
- ❑ Extractions
- ❑ Dental trauma
- ❑ Space maintainer
- ❑ Other (specify)
- ❑ Nitrous oxide
- ❑ Conscious sedation
- ❑ General anesthesia
- ❑ Special needs
- ❑ Pathology

Comments:_____

_____

❑ X-rays emailed ❑ X-rays given to parent ❑ Needs X-rays

Referring doctor/practice: _____

Phone: _____ Email: _____