Portland
CHILDREN'S DENTISTRY

Date: .....

Name: ..... Age: ..... M / F

Parent/Guardian: .....Phone: .....

Referring Provider: .....

Reason for referral: ○ 1st dental visit ○ Toothache ○ Caries ○ Special needs
○ Behavior ○ Trauma/Emergency ○ Sedation/Anesthesia ○ Other

Radiographs: ○ None ○ X-rays sent with patient ○ Email ○ Enclosed

Referred for: ○ Comprehensive care ○ Limited treatment for: .....

Comments: .....

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Call today to make an appointment

Office location:

○ Westside Office
Free Parking

2323 NW Westover Rd Portland, OR 97210
Tel (503)893-2889 • Fax (971) 279-4578

○ Eastside Office
Free Parking

5216 SE Woodstock Blvd Portland, OR 97206
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