Kids R Us Dentistry

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Pediatric Dentistry
Telephone: (403) 640-0000
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Introducing: _____ D.O.B. _____

Reason for referral: _____

Parents' Names: _____

Parents' Phone Numbers: Cell: _____ Home: _____

Parents' Email Address: _____

Recent treatment: _____

Treatment required: _____

Behavior assessment: _____

Referred by Dr. _____ Phone: _____

Office Name: _____

Xrays - Please indicate type and date taken: _____

_____

Xrays ☐ In Mail ☐ Email ☐ Given to Patient

Parental consent to release Xrays to our office - Signature: _____