Southern Smiles
pediatric dentistry

www.southernsmileskids.com • Mark Herring, DMD

Patient name: _____ Age: _____

Parent's name: _____

Contact information: _____

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 ❑ Need X-rays

Referring doctor/practice: _____

Phone: _____ Email: _____

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