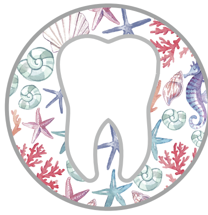

Patient Name: ______________________________

Referring Doctor: ______________________________

Reason for Referral: ______________________________

____

Xrays taken? ☐ Yes ☐ No

Recommend any of the following? ☐ Nitrous ☐ Oral Sedation ☐ General Anesthesia

Additional Notes: ______________________________

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Please email Xrays to cd@cdentistry.comcastbiz.net

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