WOODROFFE PEDIATRIC
DENTISTRY

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Dr. Ngoc Luong Dr. Arlene Martin

DATE _____/_____/_____
D M Y

Patient Name_____ **DOB** _____/_____/_____ **M / F**
D M Y (circle)

Parent/Guardian Names_____

Tel (H)_____ **Address**_____

Tel Mom (w)_____ **(cell)**_____

Tel Dad (w)_____ **(cell)**_____

E-mail _____

Last Dental Visit____/____/____ **Treatment Performed:**_____
D M Y

How Did Child Respond? _____

Referral For: Consultation ☐ Restoration ☐ Regular Care ☐

Radiographs: Forwarded ☐ With Patient ☐ None ☐

Treatment Required:_____

_____

Referred By:_____ Office Phone #_____

Child currently in pain? YES ☐ **NO** ☐

Any additional information that we should be aware of to help us assist in the care of this child_____

_____

Please ensure this consultation appointment is booked through your office. If unable to keep this appointment please advise our office at least 48 hours prior to scheduled time

THANK YOU!

Payment:

Payment is due on the day the treatment is provided. We accept Visa, MasterCard, Debit Card and Cash. We will act on your behalf and provide your insurance company with all of the necessary information to ensure that you receive the coverage to which you are entitled.