WOODROFFE PEDIATRIC DENTISTRY
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☐ **Dr. Ngoc Luong** ☐ **Dr. Arlene Martin** ☐ **Dr. Aline Dufresne**

DATE _____/_____/_____
D M Y

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

Parent/Guardian Names_____

Tel (H)_____ (C) _____

E-mail _____Insurance _____

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: _____**TEL#**_____

Email _____ **Fax#**_____

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

Any additional information we should be aware of to help take care of this child.

_____

_____

Cancellation Policy: We require a 48 hour notice for any cancellations or changes to appointments by phone.

Payment: Payment is due in full at each visit. We accept Visa, MasterCard, Debit Card and Cash. We will act on your behalf to provide your insurance company with all necessary information to ensure that you receive any coverage to which you are entitled.