WOODROFFE PEDIATRIC DENTISTRY
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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 ☐

Radio graphs: Forwarded ☐ With Patient ☐ None ☐

Treatment Required: _____

_____

Referred By: _____ TEL# _____

Email _____ Fax#_____

Child currently in pain? YES ☐ NO ☐

Any a dditional 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.