

Beautiful Smiles Children's Dental Health, P.C.

Pediatric Dentistry and Orthodontics

www.beautifulsmileserie.com

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Patient Name _____

Appointment Information:

1. Your appointment time is reserved specifically for you. If you cannot make your appointment for any reason, please notify us at least 48 hours in advance.
2. If x-rays are being sent to our office, please call us 1-2 days prior to your appointment to confirm their arrival.
3. Your first appointment is typically for consultation only with the exception of certain situations or procedures.
4. After your appointment is made, patient information forms will be sent to you. These forms MUST be returned to our office no later than 1 week prior to your child's appointment or it will be cancelled.

Patient's last exam _____

Patient's last prophylaxis _____

Patient's last radiographs _____

Remarks: _____

Radiographs to be forwarded

Radiographs sent with patient

Referring Doctor: _____ Date: _____

Thank you for the confidence of your referral.

