Pediatric Patient Referral

Name: _____ Age: _____

Appt Date: _____ Time: _____

E-mail: _____ Tel: _____

Address: _____

Patient Concerns: _____

_____

X-Rays:

☐ Sent with patient ☐ Mailed ☐ Need to be taken

Reason for referral:

☐ Consultation (Specify): _____

☐ Complete Care ☐ Continued Care

☐ Emergency/Trauma ☐ Nitrous Oxide

☐ Extractions ☐ Conscious Sedation

☐ Habits ☐ Other: _____

For evaluation of tooth/teeth #:

E D C B A 8 7 6 5 4 3 2 1	A B C D E 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 E D C B A	1 2 3 4 5 6 7 8 A B C D E

Referred by: _____ **Tel:** _____

PEDIATRIC DENTISTRY
infants - kids - teens

Magdalena Quinn D.D.S.
478 Dundas St. West • Suite 9 • Oakville, ON L6H 6Y3
Tel: 905-257-4377 • Fax: 905-257-4378
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Where kids love to smile!

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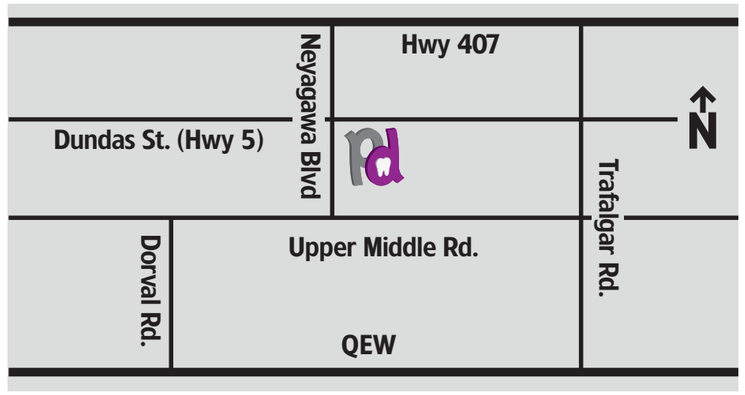
New patients welcome!
(No referral required)



Pediatric Services

- First Visit by 1st Birthday
- Preventive Dentistry
- Digital X-rays
- Conscious Sedation
- Nitrous Oxide
- Early Orthodontic Screening
- Custom Sports Mouthguards
- Emergency Trauma Care

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