Children's Dental Columbia

Heather H. Owens, D.D.S.
Gina H. Carney, D.M.D.

Patient Name _____ DOB:___/_____/_____

Parent/Guardian Name _____ Phone: _____-_____-_____

Patient Insurance ☐TNCARE ☐ Other _____

Reason for referral: Please check all that apply

☐ 1st Visit ☐ Age/Behavior ☐ Trauma/Emergency/Toothache ☐ Restorative Only
☐ Extractions ☐ Oral Sedation ☐ Hospital Case ☐ IV Sedation ☐ Special Needs

The Referring Dr. performed

Exam Date: _____
Prophy Date: _____
Fluoride Date: _____

X-rays that you are sending

Panoramic Date:_____
BWX Date:_____
Periapical Date:_____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
					A	B	C	D	E	F	G	H	I	J		
R																L
					T	S	R	Q	P	O	N	M	L	K		
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17

Notes:_____

_____

_____

Referring Doctor: _____ Date: ___/___/_____

☐ Doctor requests phone consultation

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Email: info@ChildrensDentalColumbia.com

Office Hours:
Monday-Thursday
8-5pm (Lunch 12-1pm)
Friday 8-12pm