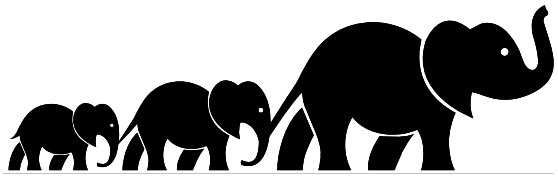

CAPITAL CITY
Pediatric Dentistry

Date: _____

Please provide a dental evaluation for:

_____

Reason for referral

☐ Pediatric dental needs:
- ☐ Infant dental care
- ☐ Management of Behavior
- ☐ Dental Decay
- ☐ Dental Infection
- ☐ Dental Trauma
- ☐ Eruption Problem
- ☐ Thumb/Finger Habit

Remarks: (A parent or legal guardian must accompany the child patient)

_____

_____

_____

_____

_____

Referring doctor: _____

2406 Blue Ridge Road
Suite 210
Raleigh, NC 27607
Office/Fax: 919-782-9560
www.capitalcitypediatricdentistry.com