# POWERS PEDIATRIC DENTISTRY

**CHRISTINA L. POWERS, DDS**
Certified, American Board of Pediatric Dentistry

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## DOCTOR REFERRAL

Name:_____ Date:_____
Referred by: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____

**Treatment provided by your office and Date:**
☐Exam ☐Prophy ☐Fluoride ☐None
☐Other_____

**Type of Radiograph taken by your office and Date:**
☐ Bitewings_____
☐ Panorex_____
☐ Periapical_____
☐ None

**Please email x-rays to images@brushingbirdie.com**

**Reason for Referral:**

| | |
|---|---|
| ☐ Pediatric Dental Needs | ☐ Infant Dental Care |
| ☐ Dental Infection | ☐ Management of Behavior |
| ☐ Dental Trauma | ☐ Dental Decay |
| ☐ Eruption Problem | ☐ Thumb/Finger Habit |

**Remarks:** (A parent or legal guardian must accompany child at appointment)

_____
_____
_____

THANK YOU FOR YOUR REFERRAL