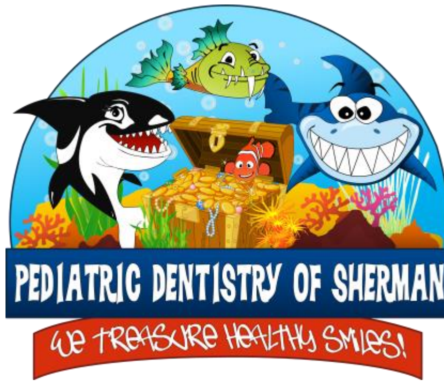

EVALUATION / TREATMENT REQUEST

Patient Name: ______________________________ Date of Birth: ____________________

Parent Name: ______________________________ Primary Phone: ____________________

Patient Insurance: (circle one) TX Medicaid | OK Sooner Care | Insurance | Private Pay

Referring Office: ______________________________ Treating Dr. ____________________

Office Address: ______________________________ Phone: ____________________

______________________________ Fax: ____________________

Referring to: (circle one) Dr. Williamson Dr. Preece Dr. Viswanathan First Available

☐ **Medical Alert(s)** ____

Date of last prophy: ____________ **X-rays within the last year?** ☐ YES ☐ NO **Date:** __________

_____ PA | _____ BWX | PANO Date:________ ☐ Sending with patient **or** ☐ E-Mailing

Treatment Requested: ____

____

____

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
				A	B	C	D	E	F	G	H	I	J				
				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	

PLEASE **FAX** THIS FORM TO **903.891.9339** OR **E-MAIL** TO: **pediatricdentistryofsherman@gmail.com**
AND GIVE YELLOW COPY TO THE PATIENT TO BRING TO THEIR APPOINTMENT

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