



pediatric dentistry

Dental care for infants, children & teens

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Date: _____

Patient's Name: _____ DOB: _____

Parent/Guardian's Name: _____ Relationship: _____

Reason for Referral: _____

- ☐ X-ray(s) provided: ☐ mailed ☐ emailed ☐ given to parent
- ☐ X-ray(s) needed
- ☐ X-ray(s) not possible
- ☐ Premedication
- ☐ Special healthcare needs, please explain

Referring Doctor _____

*Welcome to Butte Pediatric Dentistry! We are looking forward to meeting you and your family soon.
Feel free to call 406-723-KIDS (5437) to schedule your appointment today!*

