PEDIATRIC DENTISTRY OF SHERMAN

We Treasure Healthy Smiles!

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** **First Available**

Medical Alert(s) _____

Date of last prophy: _____ **Date of last x-rays:** _____

Please email x-rays to: shermanddsrecords@gmail.com

Treatment Requested: _____

_____

_____

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

AND GIVE A COPY TO THE PATIENT TO BRING TO THEIR APPOINTMENT.

2803 N Loy Lake Rd. Sherman, TX 75090 | P: 903-892-2246 | F: 903-891-9339

www.pediatricdentistryofsherman.com