



Leeward Pediatric Dentistry

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Kid Safe, Kid Friendly

Patient Name: _____ Age: _____

Parent or Guardian: _____

Referred By: _____ Date: _____

Reason for Referral: _____

Dental services completed: _____ Examination _____ Bitewing X-rays

(please date) _____ Prophylaxis _____ Anterior PA X-rays

_____ Fluoride _____ FMX or Pano X-ray

Children's Dentistry without the use of gas or sedation

