



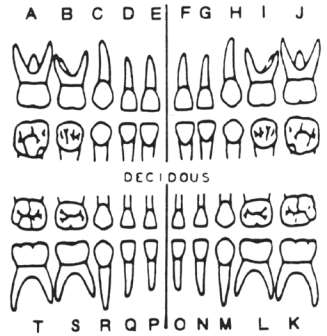
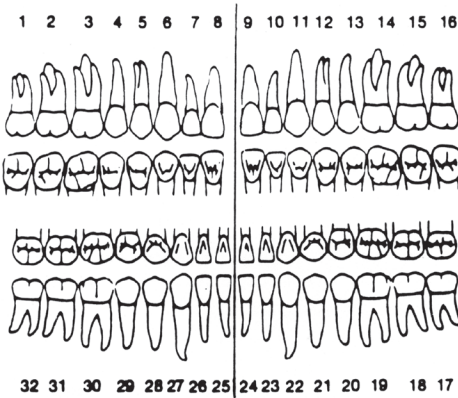
Newport
Pediatric
Dentistry

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PATIENT REFERRAL

My patient: _____ DOB: _____

Needs: _____



Consultation: Nitrous Oxide General Anesthesia Other

Remarks: _____

Date of most recent radiographs: (please forward) _____

Referring Doctor: _____ Date: _____

Thank You