Sprout
PEDIATRIC DENTISTRY

board certified pediatric dentist — Amanda Hankins, DDS

Introducing _____ Date _____
Referred by _____ DOB _____
Phone number _____ Age _____

Reason For Referral:

- ❑ 1st Dental Visit
- ❑ Trauma
- ❑ Hospital Treatment
- ❑ Conscious Sedation
- ❑ Lip or Tongue Tie
- ❑ Decay
- ❑ Other: _____

Radiographs:: ❑ None Taken ❑ Sent with patient

Significant Medical History: _____

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 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 |

We look forward to taking care of your sprouts!

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