



DATE _____

PATIENT'S NAME: _____ AGE _____

1. CHIEF COMPLAINT _____

2. WHAT HAVE YOUR EXPERIENCES BEEN WITH THIS CHILD?

3. WHAT TREATMENT IS INDICATED? _____

4. ARE RADIOGRAPHS ACCOMPANYING THE PATIENT YES ____ NO ____

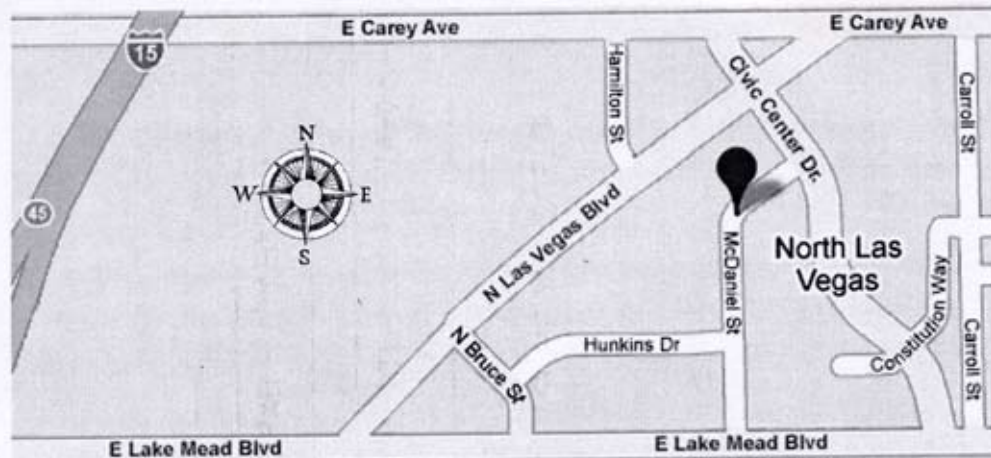
5. IS THERE ANY RELEVANT MEDICAL HISTORY WE SHOULD BE AWARE OF?

6. DO YOU THINK THIS PATIENT IS A CANDIDATE FOR IN OFFICE CONSCIOUS SEDATION
OR HOSPITALIZATION? _____

DOCTOR'S SIGNATURE _____ TELEPHONE NUMBER _____

DOCTOR'S ADDRESS _____

(see directions to our offices on reverse side)



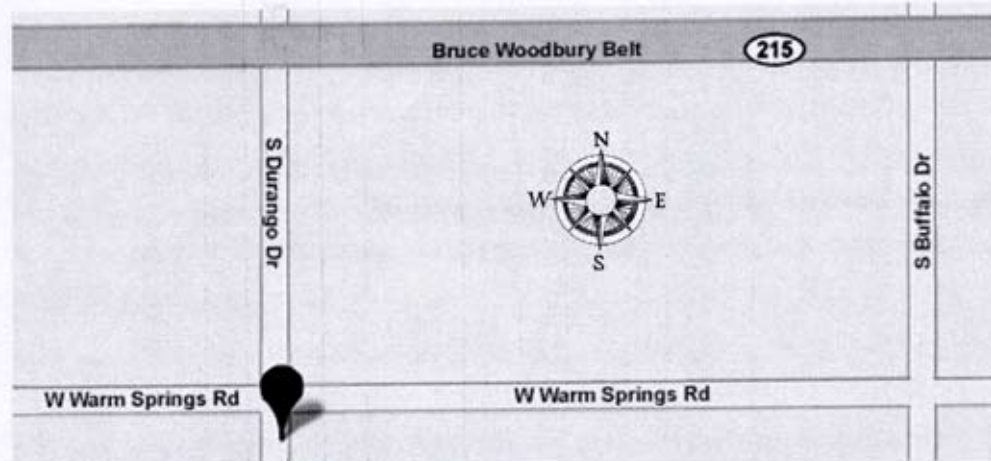
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