



AVOCABO

DENTAL & ORTHODONTICS


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Patient Information

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Email: _____

Phone: _____

Referring Office Information

Provider/Office Name: _____

Phone: _____

Date: _____

Reason for Referral

- Comprehensive Pediatric Exam
- Dental Caries Management
- Emergency/Trauma Assessment
- Sedation Consult
- Orthodontic Evaluation
- Other: _____

Scan to schedule



Radiographs / Records

- Sent with patient
- Emailed
- Please take new radiographs

Notes / Comments

Thank you for trusting us with your patients!