Pediatric Dental Care Under General Anesthesia

Jason Tanguay, DDS

mint. dental studio

Patient Info:

Patient Name _____ Date _____

Parent / Guardian _____ Patient Birthdate _____

Phone (primary) _____ Referring Provider _____

Phone (alternate) _____ Provider Contact # or Email _____

Dental findings / Preliminary treatment plan (if known):

Pertinent medical history or other comments:

☐ Dental Providers: Please check here if you are able to email any recent radiographs and send to: info@refreshingdentistry.com

Thank you for your referral!

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