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**Carla LaLande DMD, MSD**

Date \_\_\_\_\_

Introducing: \_\_\_\_\_ DOB \_\_\_\_\_ M\_\_ F\_\_

❖ Referring Doctor Name: \_\_\_\_\_  
Referring Doctor Phone: \_\_\_\_\_

❖ Guardian Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

❖ X-Ray (check one)  
 E-mailed to info@tinytooth.com  
 Sent with Patient  
 Take X-Ray

❖ Reason for Referral / Procedure to be Performed  
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