PEDIATRIC DENTISTRY

DR.KWON

HEALTHY SMILES, HAPPY PARENTS

DATE _____

PATIENT'S NAME _____ AGE _____

1. CHIEF COMPLAINT _____

_____

2. WHAT HAVE YOUR EXPERIENCES BEEN WITH THIS CHILD? _____

_____

3. WHAT TREATMENT DO YOU FEEL IS INDICATED? _____

_____

4. ARE RADIOGRAPHS ACCOMPANYING THE PATIENT? ☐ YES ☐ NO

IF NOT, WHY? _____

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 AT SCOTTISH RITE CHILDREN'S HOSPITAL?

☐ YES ☐ NO

DOCTOR'S SIGNATURE _____

TEL. NUMBER _____

PLEASE INFORM YOUR PATIENT THAT TREATMENT WILL BE SCHEDULED ONLY AFTER AN EXAMINATION.

CHOOSE A LOCATION:

☐ **HAMILTON MILL LOCATION**
3590 BRASELTON HWY, SUITE 201, DACULA, GA 30019 – 678.714.7575

☐ **FLOWERY BRANCH LOCATION**
4009 WINDER HWY, SUITE 200, FLOWERY BRANCH, GA 30542 – 678.696.2200

☐ **LOGANVILLE LOCATION**
2101 BAKER CARTER DR, SUITE 200, LOGANVILLE, GA 30052 – 678.783.6400

☐ **ATHENS LOCATION**
1795 RESURGENCE DR, SUITE 101, WATKINSVILLE, GA 30677 – 706.719.3910

WWW.KWONSMILES.COM