



CHILDREN'S DENTAL CENTER OF MADISON, S.C.

Date: _____

Introducing: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

Please mark services you performed:

- Prophylaxis Date: ____/____/____
- Fluoride
- Exam
- Sealants - Date Completed: ____/____/____
- Treatment was/was not attempted

If x-rays were taken:

- Bitewings
- Panorex
- Periapical
- Emailed (Note: emails listed below)

Remarks: _____

Referred by Dr.: _____ Phone: _____

Referred by Clinic: _____

Appointment: _____ Time: _____

Initial appointment will be for examination and consultation only.

Your appointment is at the location checked below. Map of locations on backside.

Daniel J. DeJarlais, D.D.S.
Britney Bries, D.M.D.
Liam Smyth, D.D.S.

Eric A. teDuits, D.D.S., M.S.
Allison L. Dowd, D.D.S.
Drew teDuits, D.D.S.

Anthony R. Hernandez, D.D.S.

Cecelia L. Thompson, D.D.S.
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