

Todd M. Young, DDS Pediatric Dentistry

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Patient: _____ Date: _____

Referring Dr: _____ Phone: _____

For:

Emergency treatment/trauma

Sedation/hospital dentistry

Comprehensive treatment

Limited treatment _____

Comments:

An appointment has been scheduled for your child with
Dr. Young On:

Date: _____ Time: _____

Young
KIDZ
dental

