Happy Teeth
DENTISTRY

Dr. Brianna Ganson, DDS

Patient's Name:_____

Date:_____ Patient's Phone Number: _____

☐ Consultation _____ ☐ Emergency Care _____

☐ Sedation _____ ☐ Hospital Dentistry _____

Our Office:

☐ Will send recent BWs

☐ Will send a recent Pano

☐ Would like your office to take the necessary x-rays

Date of last Prophylaxis:_____

Reason for Referral: _____

_____

_____

Referring Doctor's name:_____D.D.S . / M.D.

Phone:_____

Your first appointment will consist of an initial examination, cleaning and radiographic evaluation unless otherwise specified.

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