



VICTORIA PEDIATRIC DENTAL CENTRE

DR. ANITA GADZINSKA-MYERS INC

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Board Certified Specialist in Pediatric Dentistry

Patient Name: _____ DOB: _____

Parent(s) Name: _____

Address: _____ Phone: _____

Insurance Info.: _____

Consultation Regarding:

16 - 55 54 53 52 51

61 62 63 64 65 - 26

36 - 85 84 83 82 81

71 72 73 74 75 - 36

Other: _____

Describe Child's Level of cooperation: _____

Radiographs:

☐ Please take

☐ Enclosed

☐ E-mailed to vpdc1830@outlook.com

Referred by DR. _____ Phone: _____
(first & last name)

Thank you for your referral. We sincerely appreciate your trust!