



**Dr. Neeru Ramaswami, BDS, MS, MPH, FAAPD**

*Board Certified Specialist in Pediatric Dentistry*

Patient Name \_\_\_\_\_

Patient Age \_\_\_\_\_

Reason for Referral \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Last X-rays \_\_\_\_\_

X-rays Included     yes             no             sent by mail

Referring Doctor \_\_\_\_\_

*(please print name)*

Referring Doctor's Phone # \_\_\_\_\_

**Phone: 517.574.4688**

**Fax: 517.574.5894**

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