



Avni C. Rampersaud, D.D.S., P.A.

Diplomate, American Board of Pediatric Dentistry

Date: _____

Patient's Name: _____ Age: _____

Parent or Guardian: _____

Contact Number(s): _____

Reason for Referral: _____

Date of Last Exam & Cleaning: _____

Available Radiographs & Date Taken:

- PANO: _____
- BW's: _____
- PA's: _____

Referring Doctor: _____

Phone Number: _____

Email: _____

Please email this referral to our office and share a copy with the parents. We would be happy to reach out to the family to schedule an appointment, or they are welcome to contact us directly.

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Email: chdds@bigsmiles4kids.com