



PEDIATRIC DENTISTRY

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Sioux Falls, SD 57108

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COMPASSIONATE DENTAL CARE FOR KIDS

Child's Name _____ DOB _____

Parent/Guardian's Name _____

Cell Phone _____ Home Phone _____

Email _____

Areas of Concern/Reason for Referral

X-rays Taken? ☐ Yes ☐ No Date of X-rays _____

***Please e-mail referral form and all x-rays to info@abcdentalkids.com**

Is family interested in teledentistry consultation? ☐ Yes ☐ No

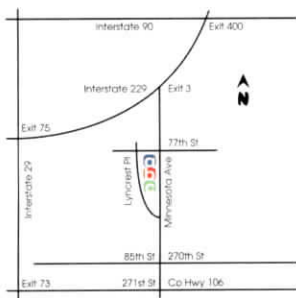
Referring Doctor _____

Practice Name _____

Doctor's Office Phone _____ Today's Date _____

Doctor's Address _____

City _____ State _____ Zip _____



At ABC Pediatric Dentistry, parents
are welcome to remain with their child
during all appointments.



www.abcdentalkids.com