



**SPITZ DAVIS**  
PEDIATRIC DENTISTRY

**TREATMENT REQUEST**

- Dr. Charles Spitz
- Dr. Tyler Davis

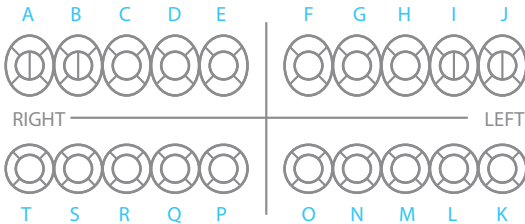
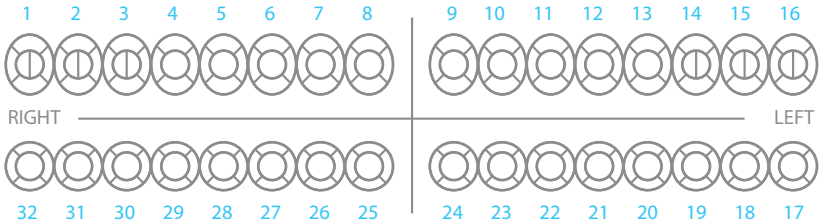
Patient: \_\_\_\_\_

Parent: \_\_\_\_\_

Referred By: \_\_\_\_\_ Date: \_\_\_\_\_

X-rays:  Emailed to: office@spitzanddavis.com

Emailed to: \_\_\_\_\_



Remarks: \_\_\_\_\_

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