Pediatric Dental
ASSOCIATES

REFERRAL SLIP

DATE: _____

INTRODUCING: _____DOB: _____

CONTACT NAME: _____ PHONE: _____

REFERRED BY: _____

INSURANCE COMPANY: _____ I.D. NUMBER: _____

X-RAYS TAKEN? ☐ YES ☐ NO TYPE OF FILM(S): _____ DATE OBTAINED: _____

REASONS FOR REFERRAL:

☐ SEDATION ☐ APPREHENSIVE BEHAVIOR ☐ EXTENT OF TREATMENT ☐ OTHER _____

TEETH AFFECTED:

_____

_____

TREATMENT RENDERED/ATTEMPTED:

☐ PROPHY ☐ FLUORIDE ☐ RESTORATIONS DATE: _____

COMMENTS:

_____

_____

_____

_____

PLEASE FORWARD X-RAYS TO EMAILS LISTED BELOW

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