



Referral for Pediatric Dental Care

Andrew M. Heaton, DDS

701 Indian Trail, Suite C Harker Heights, Texas 76548 / Ph: (254) 698-0641 / Fax: (254) 698-0644
forms@allstarchildrensdentistry.com

REFERRING DOCTOR		Date: _____
Referring Doctor/Office Name: _____		Have you referred to us before?
Phone Number: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address: _____		
GENERAL INFORMATION		
Patient Name: _____		DOB: _____
Mailing Address: _____		
City: _____		State: _____ Zip: _____
Parent/Guardian: _____		DOB: _____
Home Phone: _____		Cell Phone: _____
Email Address: _____		
		DENTAL INSURANCE INFORMATION
		Company: _____
		ID: _____
		SSN: _____

REASON FOR REFERRAL

Consultation/Treatment Needed: _____

<input type="checkbox"/> Patient uncooperative	<input type="checkbox"/> Large amount of treatment needed
<input type="checkbox"/> Too young for our office	<input type="checkbox"/> Parent requested a Pediatric Dentist
<input type="checkbox"/> Urgent care needed	<input type="checkbox"/> Oral sedation needed
<input type="checkbox"/> Moderate treatment needed	<input type="checkbox"/> IV sedation needed
<input type="checkbox"/> Basic care needed	<input type="checkbox"/> General anesthesia needed
<input type="checkbox"/> Special needs-please explain below	
Relevant Medical History: _____	

Please note all procedures completed in your office at most recent visit.

<input type="checkbox"/> Comprehensive Exam	<input type="checkbox"/> Periapicals
<input type="checkbox"/> Bitewings	<input type="checkbox"/> Prophy

<input type="checkbox"/> No radiographs available	<input type="checkbox"/> Recommended treatment enclosed
<input type="checkbox"/> Radiographs sent via Email	<input type="checkbox"/> Notify on completion
<input type="checkbox"/> Radiographs sent via standard mail	<input type="checkbox"/> Radiographs sent with parent

Referral information can be mailed, faxed or emailed to our office. Radiographs should be mailed, emailed, or sent with the parent. Thank you for your trust.