Referral for Pediatric Dental Care

701 Indian Trail, Suite C Harker Heights, Texas 76548 / Ph: (254) 698-0641 / Fax: (254) 698-0644
infoallstar@d4c.com

REFERRING DOCTOR

Date: _____

Referring Doctor/Office Name: _____

Have you reffered to us before?

Phone Number: _____ ☐ Yes ☐ 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: _____

_____

☐ Patient uncooperative
☐ Too young for our office
☐ Urgent care needed
☐ Moderate treatment needed
☐ Basic care needed
☐ Special needs-please explain below

☐ Large amount of treatment needed
☐ Parent requested a Pediatric Dentist
☐ Oral sedation needed
☐ IV sedation needed
☐ General anesthesia needed

Relevant Medical History: _____

_____

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

☐ Comprehensive Exam
☐ Bitewings
☐ Periapicals
☐ Prophy

☐ No radiographs available
☐ Radiographs sent via Email
☐ Radiographs sent via standard mail
☐ Recommended treatment enclosed
☐ Notify on completion
☐ 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.

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