Patient Referral Form

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Referring Doctor

Doctor Name:
Clinic Name:
Clinic Phone number:

Date of referral: day / month / year

Patient Information

Patient Full Name:
Gender: ☐ Male ☐ Female
Age:

Date of Birth: day / month / year

Parent/Guardian Name:
Relation to Patient:
Phone number:
E-mail:

Address:

Insurance information:
Company
Certificate #
Group #

Reason for Referral

☐ Patient needs a pediatric dental home
Patient needs pediatric specialty care due to age or level of cooperation. Patient will be referred back to your office when specialist care is no longer requried.

☐ Specific procedure needed
Please specify procedure(s) below. Patient will be referred back to your office following completion of the requested procedure(s).

☐ Urgent Referral
Patient requires an urgent appointment. Patients seen within 5-10 business days of referral.

☐ EMERGENCY
True dental emergency. Patient seen on same day the referral is received. Please specify nature of emergency below.

Comments and other relevant dental and medical history

Appointment Scheduling

☐ Please contact patient to schedule appointment
☐ Patient will contact your office to schedule appointment
☐ Patient already has an appointment booked at your office

Radiographs

☐ None available
☐ E-mailed. Date taken:

☐ Our office requires more referral pads

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