
 (248)749 5141

 (248)749 5131

Referring Doctor/Office : _____

First Name: _____

Last Name: _____

Birth Date: _____

Gender: ☐ Male ☐ Female

Reason for Referral

☐ 1st Dental Visit

☐ Special Needs

☐ Establish Dental Home

☐ Emergency Toothache

☐ Trauma

☐ Space Maintainer

☐ Nitrous Oxide

☐ Extensive Decay

☐ Sedation/General Anesthesia

Dental Radiograph

☐ None Available

☐ Sent to Patient Email

NOTES

Doctor Signature

Date

 2180 Dixie Hwy
Waterford, MI, 48328