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www.pediatricdentistryoftheozarks.com

REFERRAL FORM

Introducing: _____Age:_____
Parent/Guardian Name: _____
Phone Number: _____Date: _____

Date of last Prophylaxis/Fluoride treatment: _____
Date of last Dental exam:_____
Date of last X-rays and type: _____
X-Rays sent with patient? Yes / No

Appointment Pre-scheduled with Pediatric Dentistry of the Ozarks? Yes / No
Date: _____ Time: _____

I am referring the patient for the following reason(s): _____
_____
_____
_____
_____

Referring Doctor Name: _____ Phone: _____
Please Call Referring Doctor Prior to Treatment? Yes / No

For patients: Your first visit will consist of an initial examination, cleaning and radiographic evaluation unless otherwise specified. A parent or legal guardian must be present for initial visit. Please bring to your first appointment: (1) X-rays from the referring dentist, if given to you [X-rays must be of diagnostic quality or new x-rays will be taken], (2) A list of your medications and other health information, (3) Any dental/medical insurance, including your insurance card, (4) Completed new patient forms that may be downloaded and printed from our website. If you need premedication due to certain health conditions, please call your pediatrician and notify our office.

•Thank you for your referral to our office!•