KIDS TOWN PEDIATRIC DENTISTRY

REFERRAL FORM

PATIENT INFORMATION:

Today's Date: _____

First Name: _____ Last Name: _____

Patient Date of Birth: _____

Parent / Guardian Name: _____

Contact Telephone: Contact E-Mail : _____

REFERRING DOCTOR'S INFORMATION:

Referred by: _____

Telephone: E-Mail: _____

REASON FOR REFERRAL:

☐ Patient requires sedation to complete treatment

☐ Referred by Orthodontist for Ortho extraction

☐ Frenulectomy Consult

☐ Other: _____

X-RAY REQUEST:

PLEASE E-MAIL ALL X-RAYS TO: ktinfo4kids@gmail.com

☐ No X-rays taken

☐ X-rays taken and emailed to ktinfo4kids@gmail.com

Please list any other information you feel the doctor would need to know about the referring patient:

_____

_____

If you should have any questions or concerns or would like to speak with a Kids Town Team Member please contact us at: 801-217-3359

Submit