



1240 W. Danforth Rd. Edmond, OK 73003
 Phone Number: (405) 285-3855
 E-mail Address: CombsPediatricDentistry@gmail.com
 Dr. Kyla D. Combs

Referral Form

Date:		Patient Name:	
DOB:		Guardian Name:	
Phone Number:			
Referring Office/Doctor:		Referring E-mail Address:	

Reason for Referral:	<input type="checkbox"/> 1 st Dental Visit <input type="checkbox"/> Toothache <input type="checkbox"/> Decay <input type="checkbox"/> Sedation / Anesthesia <input type="checkbox"/> Trauma/Emergency <input type="checkbox"/> Other: _____
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Treatment been attempted:
<input type="checkbox"/> Yes <input type="checkbox"/> No

Radiographs:
<input type="checkbox"/> None Available <input type="checkbox"/> E-mailed / Sent to Office

Is there any clinical information, medical diagnoses, or other relevant information you would like for Dr. Combs to know?

Please, email or fax completed form with radiographs.
 We look forward to providing a fun and positive dental experience for for your child!

