Pediatric Dental CARE
Dr. Kilareski, Dr. Kremser and Dr. Ellis

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Diplomate, American Board of Pediatric Dentistry Diplomate, American Board of Pediatric Dentistry

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Dear Referring Doctor,

We want to thank you for the kind referral and trust in sending your patient to Pediatric Dental Care (PDC). We understand and respect your time and your patient's time. We can provide same day treatment under general anesthesia to minimize the number of visits and travel time for your patients and families. We require additional information on these patients/families to best service them. Below is a checklist detailing the required information and documentation to efficiently schedule them.

Once we have all the completed information, we will reach out to the patient's family. Please keep in mind our scheduling wait times may vary up to 2-3 months in the future. Please be sure to communicate this to your patients/families prior to us calling them so they are aware of the potential time frame.

Please provide the following listed items below and return to PDC via email/fax.

- Completed referral detailing the need for treatment under general anesthesia
- Treatment plan
- Dental radiographs and/or clinical photos of dentition (We **MUST** have at least one quality set of diagnostic radiographs or photos to schedule same day treatment)
- Medical history
- Copy of all medical and dental insurance cards (please include front and back)

Important Contact Information:

- Office #: (814)-238-7120
- Fax #: (814)238-2981
- Email: appointments@pediatricdentalcare.org

Pediatric Dental Care is always here to answer any questions and assist you through this process. Please reach out with any questions you may have. Thank you for trusting us with your patient's care.

The Pediatric Dental Care Team

Reminder: Please forward all forms and attach additional documents and radiographs as requested above.

Online referral: visit www.pediatricdentalcare.org/referrals/

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1019 Ghaner Road
Suite 100
Port Matilda, PA 16870
www.pediatricdentalcare.org

814.238.7120
fax 814.238.2981

Today's Date:_____ Referred to: **Pediatric Dental Care**

Patient's Legal Name: _____
Date of Birth:_____ ❑ Male ❑ Female
Special Health Care Needs: ❑ No ❑ Yes _____
Parent/Legal Guardian:_____
Home Phone:_____ Work Phone:_____

Last Examination:_____ Planned treatment: ❑ Completed ❑ Deferred
Oral hygiene: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Caries history: ❑ None ❑ Low ❑ Moderate ❑ High

Remarkable clinical findings:
- ❑ Caries
- ❑ Developmental anomalies
- ❑ Nonnutritive habits
- ❑ Maloclusion/ Space management
- ❑ Traumatic injury
- ❑ Other_____

Radiographic history/date
- ❑ Bitewings _____
- ❑ Panoramic _____
- ❑ Full mouth _____
- ❑ Single tooth _____
- ❑ Cephalogram _____
- ❑ Other _____

Comments _____
_____
_____
_____

Radiographs enclosed: ❑ Yes ❑ No

Behavior: ❑ Cooperative ❑ Previous Difficulties ❑ Ongoing considerations
Comments _____

Follow-up care to be provided by: ❑ Pediatric Dental Care ❑ Referring Dentist

_____ _____
Print Doctor's Name **Referring Doctor's Signature**