



Pediatric Dental — CARE —

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Today's Date: _____

Referred to: Pediatric Dental Care

Patient's Legal Name: _____

Date of Birth: _____

☐ Male ☐ Female

Parent/Legal Guardian: _____

Dental Insurance: _____ ID Number _____

Home Phone: _____ Work or Cell Phone: _____

Last Examination: _____ Planned Treatment: ☐ Completed ☐ Deferred

Special Health Care Needs: ☐ No ☐ Yes _____

Oral Hygiene: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Caries history: ☐ None ☐ Low ☐ Moderate ☐ High

Reason for referral:

☐ Caries/Decay ☐ Extractions ☐ Trauma/Injury ☐ 1st Visit

☐ Nitrous Oxide ☐ Conscious Sedation ☐ General Anesthesia

FINDINGS: _____

Radiographs Enclosed: ☐ Yes ☐ No Date Taken: _____

Send to appointments@pediatricdentalcare.org

Behavior: ☐ Cooperative ☐ Previous Difficulties ☐ Ongoing Considerations

Comments _____

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

Print Doctor's Name _____ Office Number _____

Referring Doctor's Signature _____