Kidsteeth
Dentistry for Children

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Patient Referral Form

Child's Name _____ Date _____

Parent/Guardian _____ Date of Birth _____

Phone _____ Approx. Weight _____

Address _____ Email _____

Treat patient and refer back ☐ Treat patient and continue to see ☐

Reason for Referral

List reason(s) for referral _____

Dental Insurance Information

1st Policy Holder _____ Date of Birth _____

Parent/Contact _____ INS CO _____

GROUP# _____ ID# _____ BASIC % _____

Plan Maximum $ _____ Used to Date _____

2nd Policy Holder _____ Date of Birth _____

Parent/Contact _____ INS CO _____

GROUP# _____ ID# _____ BASIC % _____

Plan Maximum $ _____ Used to Date _____

Radiographs

Emailed ☐ Yes, With Patient ☐ Yes, In Mail ☐ None ☐

Indicate number, type and date taken: _____

Referred By: _____ **Phone:** _____ **Email:** _____

Please complete this form and either email or fax to our office, or have the patient bring it to their appointment.