ANDOVER PEDIATRIC DENTISTRY

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REFERRAL FORM

Date:_____

Child's name:_____ **Age:**_____

Parent/Guardian's name: _____

Parent/Guardian's phone number: _____

Referring Dr's name: _____

Referring Dr's phone number_____

Why are you referring this child to a pediatric dentist specialist? Check all that apply. Please be specific.

- ☐ Behavior
- ☐ Insurance
- ☐ Medical History
- ☐ Trauma
- ☐ Other
- ☐ Possible Sedation/ General Anesthesia needed
- ☐ Complex Restorative Treatment
- ☐ Previous Negative Dental Experience

Date of Last Prophylaxis: _____

Date of Last Exam: _____

Type/ Date of Last Radiographs: _____

Thank you for your referral. We hope to serve your patients needs in a prompt and effective way!

Email to Andover Office **Email to Lawrence Office**