1986 Walton Nicholson Drive
Independence, KY 41051
Phone: (859) 356-5555
Fax: 859-456-6217

REFERRAL FORM

Patient Name _____ DOB_____

Home Adress: _____

Phone: Cell _____ Home _____

Parent's Name: _____

Reason for referral:
□ Dental Exam
□ Dental Caries
□ Dental Clearance
□ Oral Pathology
□ Tongue or Lip-tie
□ Traumatic Dental Injury
□ Other (Specify Below)

Referring Doctor information

Referring Doctor: _____ Phone: _____

Doctor's Email address: _____

Specific Instructions: _____

Today's Date: _____

Please Fax this Form to: 859-456-6217 or
Email to info@independencepediatricdentistry.com