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

REFERRAL FORM

Patient Name _____ DOB_____

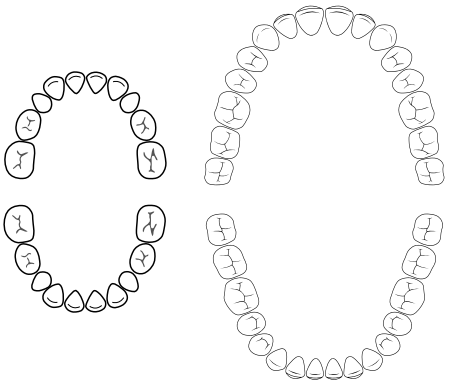
Home Adress: _____

Phone: Cell _____ Home _____

Parent's Name: _____

Reason for referral:

□ Comprehensive Care
□ Urgent Care
□ Sedation
□ Complex Medical History
□ Extractions
□ Pathology
□ Tongue or Lip-tie
□ Trauma
□ Interceptive ortho
□ Other (Specify Below)



Referring Doctor information

□ X-rays Given to Parent □ X-rays mailed/E-mailed □ Needs X-rays

Will this patient be returning to your office for comprehensive care? □ Yes □ No

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