Parvathi Pokala, DDS & Associates

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(858) 278-8700

Pediatric Referral Form

Today's Date

Refer To

REFERRING DOCTOR'S INFORMATION

First Name

Last Name

Title

Phone Number

E-Mail Address

PATIENT INFORMATION

First Name

Last Name

Date of Birth

Parent / Guardian

Insurance (optional)

Contact Phone (Home)

Contact Phone (Cell)

Contact E-Mail Address

Does the patient require antibiotics prior to dental treatment?

☐ Yes ☐ No

Treatment

REFERRED FOR THE FOLLOWING:

- ☐ Caries/Decay
- ☐ Extraction - Please specify tooth #
- ☐ Missing Teeth
- ☐ Oral Habits
- ☐ Orthodontic Evaluation
- ☐ Pulpotomy
- ☐ SSC
- ☐ Sedation
- ☐ Other - Please specify:

Referral Notes

OTHER INFORMATION:

Would you like to discuss this case before treatment?

☐ Yes ☐ No

X-rays

☐ Attached ☐ Sent Separately ☐ None Included

PLEASE MARK TEETH / AREA TO BE TREATED: