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BOARD CERTIFIED PEDIATRIC DENTISTS

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www.smalltotall.info

Date _____

Patient _____ Phone# _____

Email _____

Referring Doctor/Provider _____

1. Reason for referral: (Specify involved area)
   - ❑ Emergency treatment _____
   - ❑ Restorative _____
   - ❑ Tongue-Tie/Lip-Tie _____
   - ❑ Other _____

2. Services Requested:
   ❑ Accept as new patient ❑ Evaluation only ❑ Specific treatment only
3. Significant Medical History/What do you need to know about this patient? _____
4. Has this patient received treatment at your office ❑ Yes ❑ No
   if yes please include significant dental history _____
5. Were X-rays taken? ❑ Yes ❑ No (If yes, please send)
6. Is patient currently enrolled in Washington Apple Health/Provider One? ❑ Yes ❑ No