small to tall
PEDIATRIC DENTISTRY

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BOARD CERTIFIED PEDIATRIC DENTISTS

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Phone 360.459.5885 • Fax 360.459.7115
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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 _____

_____

_____

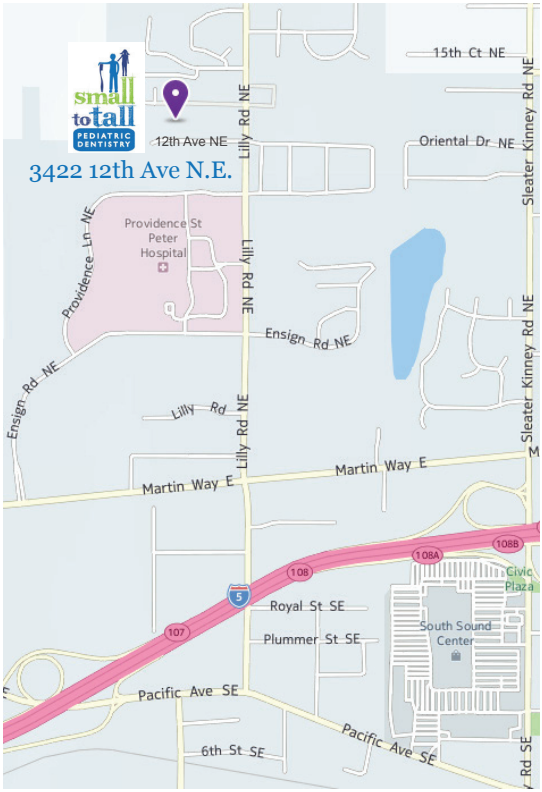
5. Were X-rays taken? ❑ Yes ❑ No (If yes, please send)

6. Is patient currently enrolled in Washington Apple Health / Provider One? ❑ Yes ❑ No

Reminders

This referral note and any pertinent X-rays should accompany you at your appointment.

Minors must be accompanied by a parent or guardian.



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