Doctor Referral Form

Kids Dental AZ

kidsdentalaz.com

Refer to: North Phoenix

Referral date: _____

2470 W Happy Valley Rd Unit 1189, Phoenix, AZ 85085

Patient and Parent / Guardian

Patient Name

Patient DOB (MM/DD/YYYY)

Parent/Guardian Name

Parent DOB (MM/DD/YYYY)

Patient Phone Number

Patient Address (street, city, state, ZIP)

Patient Insurance

Plan Name

Subscriber Name

Member / Subscriber ID

Employer

Referring Office / Doctor

Phone Number

Referring Office / Doctor Name

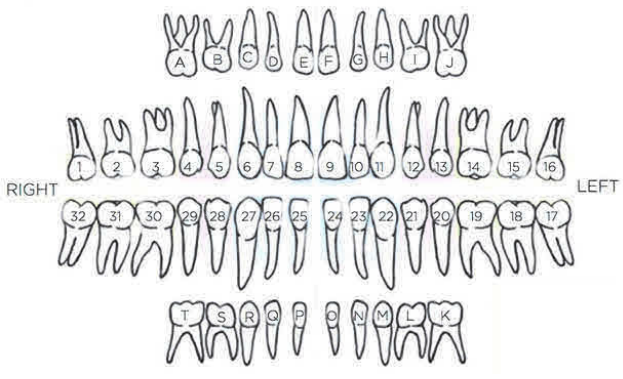
Recommended Treatment Setting

Select all that apply.

- ☐ Hospital Setting
- ☐ IV Sedation
- ☐ Oral Conscious Sedation

Universal Tooth Numbering Reference

Primary teeth are labeled A-T. Use the chart to identify teeth requiring treatment.



Primary Teeth Requiring Treatment

Select all applicable primary teeth.

☐ A	☐ B	☐ C	☐ D	☐ E
☐ F	☐ G	☐ H	☐ I	☐ J
☐ K	☐ L	☐ M	☐ N	☐ O
☐ P	☐ Q	☐ R	☐ S	☐ T

Additional Comments

Please complete and send with the patient.