PATIENT REFERRAL FORM

northeast iowa PEDIATRIC DENTISTRY

Today's Date: _____/_____/_____

Date patient was evaluated at office: _____/_____/_____

Patient name: _____Patient's DOB: _____/_____/_____

Patient address:_____

Parent's name: _____ Parent's phone (home/cell/work):_____

Y | N Dental Insurance If yes, insurance provider: _____

If Iowa Medicaid, please know our office only accepts Delta Dental of Iowa

Referring Dentist: _____ Office name: _____

Reason for referral:

- ☐ 1st Dental Visit / Infant-Tot Exam
- ☐ Decay
- ☐ Behavior
- ☐ Special health care needs
- ☐ Trauma
- ☐ Frenectomy evaluation (please circle): labial | lingual
- ☐ Advanced behavior management, including potential deep IV sedation or general anesthesia
- ☐ Other (describe below)

2	3	4	5	6	7	8	9	10	11	12	13	14	15
		A	B	C	D	E	F	G	H	I	J		
		T	S	R	Q	P	O	N	M	L	K		
31	30	29	28	27	26	25	24	23	22	21	20	19	18

Comments: _____

_____

Radiographs:

- ☐ Attempted, unable to obtain due to cooperation
- ☐ None
- ☐ Yes, date made: _____/_____/_____
  - Will be sent via (please circle): Email (preferred) | Mail | Patient will bring

To email radiographs, send to frontdesk@neiapd.com and include patient name, patient DOB, and date radiographs were made. **Our office will contact parent/patient to schedule appointment.**

Thank you!

563.382.6259 frontdesk@neiapd.com
563.538.0100 www.neiapd.com
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American Board of Pediatric Dentistry