Hospital Dentistry Referral Form

Thank you for referring your patient to Golden Pediatric Dentistry.
Please complete the form below and submit via **website, email or fax** as indicated below.

REFERRING DENTAL PROVIDER

Practice Name: _____
Referring Dentist Name: _____
Office Contact Person: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

PATIENT INFORMATION & GUARDIAN CONTACT

Child's Full Name: _____
Child's Date of Birth: ____ / ____ / _____ Age: _____
Parent / Legal Guardian Name: _____
Phone Number: _____
Email Address: _____
Primary Language (if other than English): _____

PATIENT INSURANCE INFORMATION

Insurance Company Name: _____
Subscriber's Full Name: _____
Subscriber's Date of Birth: ____ / ____ / _____
Member ID: _____
Group #: _____

Golden Pediatric Dentistry *partners closely with referring providers to ensure safe, compassionate, and coordinated care for every child.*

REASON FOR REFERRAL

(Check all that apply)

☐ Dental anxiety / inability to tolerate treatment
☐ Young age
☐ Extensive treatment needs
☐ Special healthcare needs (please specify): _____
☐ Previous unsuccessful dental treatment attempt
☐ Other (please specify): _____

MEDICAL CONSIDERATIONS

Known medical conditions: _____
Current medications: _____
Allergies: _____
Primary Care Physician Name: _____
PCP Phone Number: _____

ANESTHESIA CONSIDERATION

☐ General anesthesia recommended
☐ To be evaluated during consultation

Additional Comments or Concerns: _____
_____

Referring Dentist Signature: _____ Date: _____

SUBMIT REFERRAL TO

Website: http://www.goldenpediatricdentistry.com/for-dentists; or
Email: admin@goldenpediatricdentistry.com; or
Fax: (574) 393-9817

Once received, our team will contact the family directly to schedule a consultation, review medical history, and align on a path forward.

***Golden Pediatric Dentistry** partners closely with referring providers to ensure safe, compassionate, and coordinated care for every child.*