Phone: (574) 850-1866
Fax: (574) 393-9817
admin@goldenpediatricdentistry.com
www.goldenpediatricdentistry.com

REFERRING DENTAL PROVIDER

Practice Name:_____

Referring Dentist: _____

Phone Number: _____

Fax Number:_____

Email Address: _____

PATIENT INFORMATION & GUARDIAN CONTACT

Child's Full Name:_____

Parent / Legal Guardian Name:_____

Phone Number: _____

Email Address:_____

Primary Language (if other than English): _____

REASON FOR REFERRAL

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

ANESTHESIA CONSIDERATION

☐ General anesthesia recommended
☐ To be evaluated during consultation

Additional Comments or Concerns: _____

_____

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