



## REFERRING DENTAL PROVIDER

Practice Name: \_\_\_\_\_  
Referring Dentist: \_\_\_\_\_  
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 DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

## REASON FOR REFERRAL

*(Check all that apply)*

- Dental anxiety / inability to tolerate treatment  
 Extensive treatment needs  
 Previous unsuccessful dental treatment attempt  
 Other (please specify): \_\_\_\_\_
- Young age  
 Special healthcare needs (specify below)

## MEDICAL CONSIDERATIONS

Known medical conditions: \_\_\_\_\_  
Current medications: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Physician Phone Number: \_\_\_\_\_

## ANESTHESIA CONSIDERATION

- General anesthesia recommended  
 To be evaluated during consultation
- Additional Comments or Concerns: \_\_\_\_\_

## SUBMIT REFERRAL TO

**Website:** <http://www.goldenpediatricdentistry.com/for-dentists>; or  
**Email:** [admin@goldenpediatricdentistry.com](mailto:admin@goldenpediatricdentistry.com); or  
**Fax:** (574) 393-9817

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