

# Dentistry for Children



Board  
Certified  
Pediatric Dentists

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Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_ Apple/Medicaid:  Yes  No

Phone Number: \_\_\_\_\_ Dental Insurance(s): \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Last Prophylaxis: \_\_\_\_\_

Date of Radiographs: \_\_\_\_\_ Last Fluoride: \_\_\_\_\_

Findings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Office Email: \_\_\_\_\_

Please email form and any radiographs (inc. Pano) to: [Referral@KitsapDFC.com](mailto:Referral@KitsapDFC.com)

Thank you for your time and patience filling out this form! We appreciate you.