

Dentistry for Children



Board
Certified
Pediatric Dentists

Tongue / Lip Tie Referral

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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: _____

Parent's Concerns / Treatment Goals: _____

Findings: _____

Referring Doctor: _____ Office Phone: _____

Office Email: _____

Please email completed form to: Referral@KitsapDFC.com

Financial Policy: Payment in full is due at time of service. We can courtesy bill to certain dental insurances or parents can submit to medical insurance.