1675 Chester Ave. Suite 120
Bakersfield, CA 93301
(661) 546-8905 (661) 377-0329 FAX

Dental Treatment Referral

Date: ___________

Child's Name: ______________________________

Date of Birth: ______________________________

Special Needs: YES ☐ NO ☐

Name of School: ______________________________

Parents Name: ______________________________

Address: ______________________________

Phone #: ______________________________

Name of Medical Insurance: ______________________________

Medical Insurance #: ______________________________

Name of Primary Dental Insurance : ______________________________

Dental Insurance # ______________________________

Name of Secondary Dental Insurance: ______________________________

Dental Insurance # ______________________________

Name of Referring Nurse: ______________________________

Nurse's Email Address: ______________________________

School District: ______________________________

Nurse Phone # ______________________________

Reason for Referral: ______________________________

		Mark Box X		Mark Box X	If yes, how many teeth?
Anterior Decay?	Yes		No		
Posterior Decay?	Yes		No		
Infection Present?	Yes		No		
Pain Involved?	Yes		No		

Comments:

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Rev. 6/23 ______________________________