1675 Chester Ave. Suite 100
Bakersfield, CA 93301
(661) 546-8904 (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 07/24 ____________________