Kern County Children's

DENTAL HEALTH NETWORK

1800 30th Street, #230
Bakersfield, CA 93301
(661) 377-0322 (661) 377-0329 FAX

FIRST 5 KERN

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		
Comments:	Pain Involved?	Yes		No		

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