Quest | PEDIATRIC DENTISTRY & ORTHODONTICS

Doctor's Referral Form

Patient Information

Today's Date ____________________

First Name ____________________ Last Name ____________________ Date of Birth ____________________

Parent/Guardian ____________________ Phone ____________________ Email ____________________

❏ Patient will call for appointment ❏ Please call patient

Insurance Information

Provider____________________ ID# ____________________

Subscriber Name ____________________ Date of Birth ____________________

Does the patient require antibiotics prior to dental treatment? ❏ Yes ❏ No

Referring Doctor Information

Referred By ____________________ Practice Name ____________________

Phone ____________________ Email ____________________

Other Procedures (see chart below)

❏ Extraction ❏ Biopsy ❏ Infection

❏ Lesion Evaluation ❏ Exposure ❏ Filling, Crowns

❏ Soft Tissue ❏ Frenectomy

❏ Other: ____________________

Orthodontic Consultation

❏ Crowding ❏ TMJ ❏ Cleft Lip and Palate ❏ Cosmetic

❏ Other: ____________________

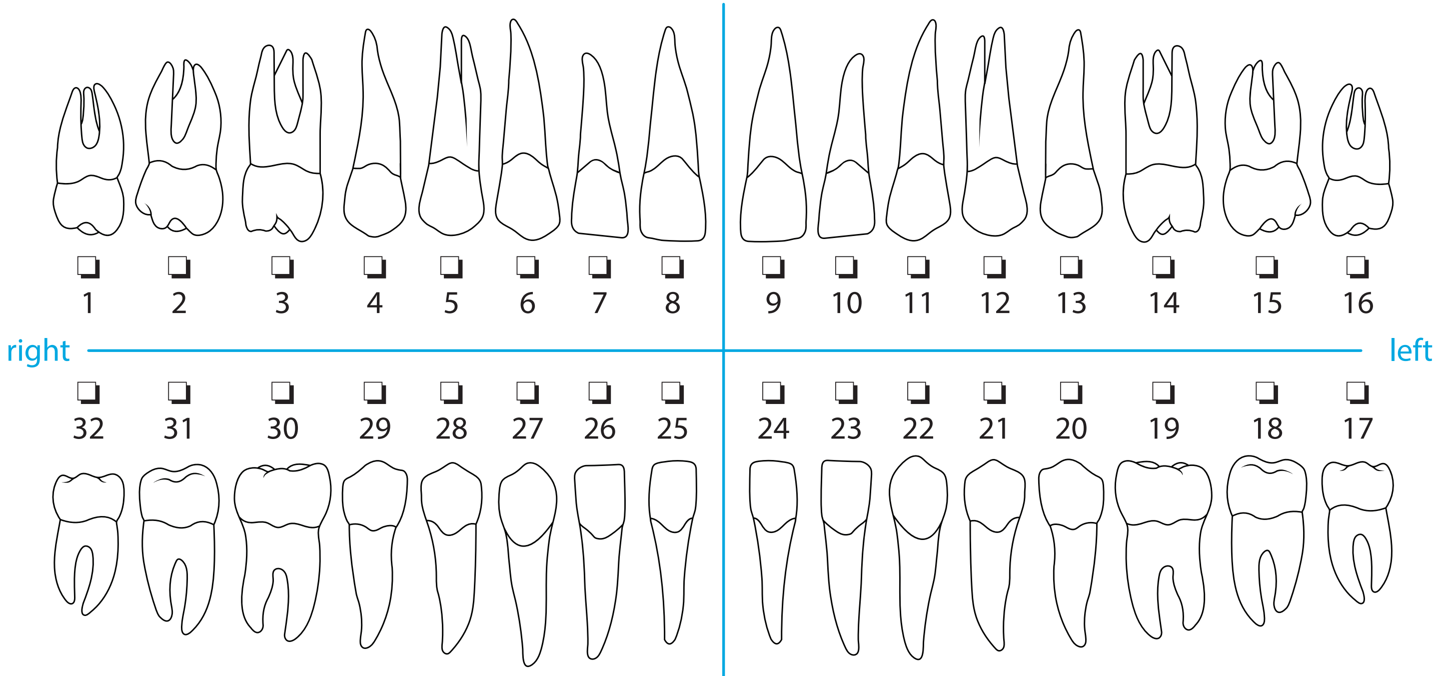
Radiographs/Clinical Photos

❏ Please Take ❏ No X-Ray ❏ Attaching (after submitting form)

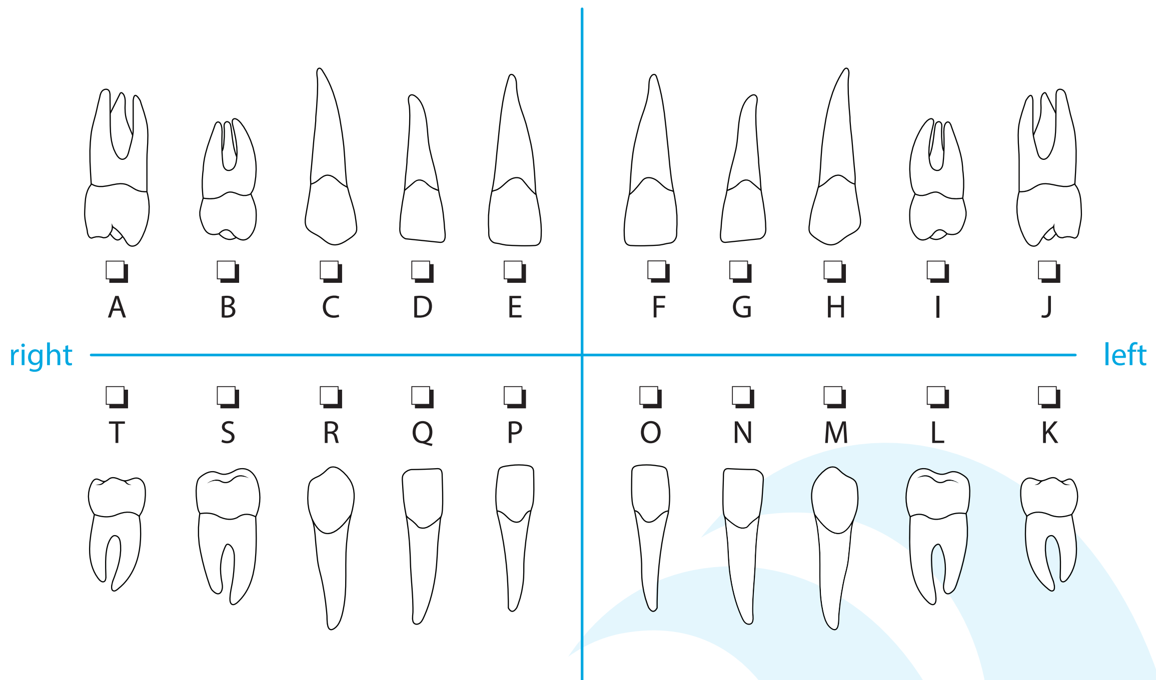
❏ Date of Xrays ____________________

Continued...

❑ Extractions or ❑ Restorations of Permanent Teeth



❑ Extractions or ❑ Restorations of Primary Teeth



Case Notes