Little Sunshine® Pediatric Dentistry

AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth

PATIENT REFERRAL

INTRODUCING: _____

APPOINTMENT DATE & TIME: _____

*Please call **425-775-1010** to schedule your patient's appointment.*

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

DATE:_____ REFERRING DR._____ PHONE:_____

This patient is being referred for evaluation of the following:

- ☐ Caries/Decay
- ☐ Extractions - Tooth #____
- ☐ Fractured Tooth
- ☐ Growth and Development
- ☐ Missing Teeth
- ☐ Oral Habits
- ☐ Orthodontic Evaluation
- ☐ Periodontal Condition
- ☐ Pulp Therapy - Tooth #____
- ☐ Other:_____

Patient also presents with and requires additional care due to:

- ☐ Autism
- ☐ Behavioral Disability:_____
- ☐ Down's Syndrome
- ☐ Mental Disability:_____
- ☐ Physical Disability:_____
- ☐ Other:_____

Comments:_____

_____

☐ **Please call me before proceeding with treatment.**

☐ **I have sent radiographs for your evaluation.**

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