Kids R Us Dental
& Adult Dentistry

DENTAL REFERRAL FORM

FROM

_____
_____
_____
_____
_____

TO

Kids R Us Dental & Adult Dentistry
325 Old Newport Blvd, Suite 3,
Newport Beach, CA, 92663
(949)-873-5710
kidsrusdental1@gmail.com

PATIENT INFORMATION

Full name: _____
Birthdate: _____
Address: _____
_____
_____
Contact number:

Parent/Guardian: _____
Contact Number: _____

REASON FOR REFERRAL

❑ **Consultation** Re:

_____
_____
_____
_____

❑ **Treatment** (as requested)

Please provide specialist with appropriate details of the problem; i.e. urgency, areas of concern, using F.D.I. tooth numbering system

RELEVANT HISTORY

(Indicate any special factors - either dental or medical - such as known allergies and specific medical problems relevant to diagnosis and treatment.)

_____

_____

_____

_____

_____

- ❑ Please call the patient.
- ❑ Patient will call.
- ❑ An appointment has been made.

  Appointment date: _____
- ❑ Radiographs are enclosed.
- ❑ Please return radiographs after use.
- ❑ Notify on completion.
- ❑ Please report - written
- ❑ Please report - by phone
- ❑ Post-referral maintenance
  - ❑ By specialist
  - ❑ In this office
  - ❑ To be discussed
- ❑ Other records are available.

Signed _____

Date _____