COLLEGE OF DENTISTRY

Pediatric Dentistry Clinic
801 South Paulina Street
Chicago, Illinois 60612-7211
Phone: (312) 996-7532
Fax: (312) 413-3400

REFERRAL FORM

Please Fax this Form to : (312) 413-3400
or Email to dentpediatrics@uic.edu

Patient Name _____ Age_____

Phone: Home ( ) _____ Work ( ) _____

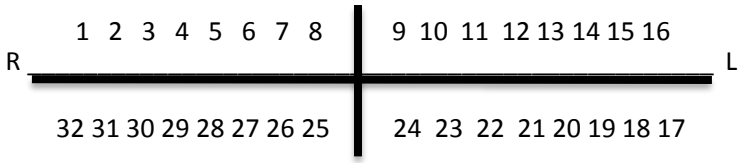
Parent's Name: _____

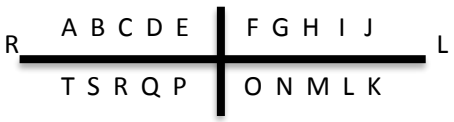
Special Health Concerns: _____

Patient INSURANCE information (including plan): _____

Reason for referral:

- ☐ Pain
- ☐ Trauma
- ☐ Special Needs
- ☐ Rampant Caries
- ☐ Behavior/Age
- ☐ Extractions
- ☐ Pathology
- ☐ Sedation
- ☐ General Anesthesia
- ☐ Interceptive orthodontic treatment
- ☐ Other:_____
  _____





Referring Doctor information

☐ X-rays Given to Parent ☐ X-rays mailed/E-mailed ☐ Needs X-rays

Referring Doctor: _____ Phone: _____

Doctor's Email address: _____

Today's Date: _____