Hospital Referral Form

Address: 1237 16th St NE Hickory, NC 28601
Phone: (828)-358-4844
Email: info@harmonybranchdentistry.com
Website: www.harmonybranchdentistry.com

Referring Provider Information

Referring Doctor/Provider Name: _____

Practice Name: _____

Phone Number: _____

Email: _____

Fax (if applicable): _____

Patient Information

Patient Full Name: _____

Date of Birth: ____ / ____ / _____

Gender: ☐ Male ☐ Female ☐ Other

Parent/Guardian Name(s): _____

Parent/Guardian Phone: _____

Parent/Guardian Email: _____

Insurance Information (if applicable): _____

Reason for Referral (check all that apply)

☐ Early Childhood Caries

☐ Dental Abscess or Infection ☐ Complex Medical History

☐ Behavior Management Needs

☐ Dental Trauma

☐ Special Healthcare Needs

☐ Surgical Evaluation (e.g., OR/GA)

☐ Orthodontic Evaluation

☐ Other: _____

Relevant Medical History / Notes

Attachments Included

☐ X-rays

☐ Clinical Notes

☐ Medical History

☐ Insurance Information

☐ Other: _____

Signature of Referring Provider: _____ Date: ____ / ____ / _____