Harmony Branch
PEDIATRIC DENTISTRY

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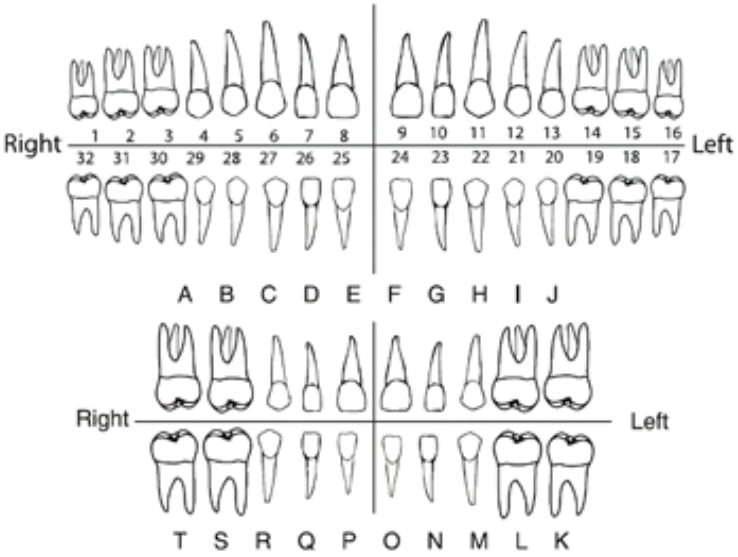
Patient Name: _____ **DOB:** _____

Parent/Guardian: _____ **Phone:** _____

Referring Doctor: _____ **Phone:** _____

Requested Evaluation / Treatment **(please chart below if needed)**

❑ Space Maintainers ❑ Extractions ❑ Hospital Dentistry ❑ Restorative Procedures ❑ High Anxiety
❑ Pediatric Surgery ❑ Oral Conscious Sedation ❑Pediatric Dental Home ❑Frenectomy
❑ Other: _____



Additional Comments or Concerns: _____

_____

Please indicate if/when the following treatment was last completed:

PANO: **Y / N** Date: _____

X-RAYS: **Y / N** Date: _____

Was in-office treatment attempted? **Y / N** Date: _____

Complete and sign the referral form. Then send to the doctor via one of the following options:

1. Email: Send to the Office Email: **info@harmonybranchdentistry.com**

2. FAX: Print the form. Then, Fax it to us at: **828-358-4845**

3. In Person: Print the form. Give to the patient to deliver to the doctor's office.
   -Make sure parent calls to book an appointment.