All·Kids·Dental
PEDIATRICS & ORTHODONTICS

Referral Form to use by community dentist when

REFERRING TO ALL KIDS DENTAL

(Fill out and send to records@akdsmiles.com with dental x-rays)

Practice/clinic name:_____

Referring Dentist's name:_____

Best Phone Number to reach the provider making this referral:_____

Patient Name:_____ Date of Birth:_____

Parent/Guardian Name:_____ Parent/Guardian Date of Birth:_____

Contact Phone:_____

Insurance Company:_____

Group/Medicaid Number:_____ Subscriber ID:_____

Reason for Referral:_____

Caries on Teeth#:_____

Pulp therapy on Teeth #:_____

X-rays taken: ◯ YES ◯ NO Date of X-rays:_____ X-rays attached: ◯ YES ◯ NO

BEHAVIORAL CONCERNS

- ◯ Pre-cooperative behavior
- ◯ Need for conscious sedation
- ◯ Need for general anesthesia
- ◯ Other_____

OFFICE PREFERENCE

- ◯ Glenwood Springs
- ◯ Eagle
- ◯ Rifle

Glenwood Springs • **Eagle** • **Rifle** • **Aspen** *(ortho only)*

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