Waterloo
PEDIATRIC DENTISTRY

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Waterloo, IA 50701

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Phone: 319-595-2160
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Date of Referral: _____

Referred by: _____

Patient Name: _____ Patient DOB: _____

Parent/Guardian Name: _____ Phone Number: _____

Referred for (check all that apply):

- ☐ Comprehensive care
- ☐ Limited Care
- ☐ Emergency or Trauma
- ☐ Pain or Toothache
- ☐ Decay
- ☐ Anxiety or Behavior Management
- ☐ Nitrous Oxide, Oral Conscious Sedation or General Anesthesia
- ☐ Special Healthcare Needs or Complex Medical History (please explain below)

Teeth to be treated: _____

Date of Last Exam: _____ Date of Last Prophylaxis: _____

Date of Last X-rays (check all that apply):

- ☐ Bitewings: _____
- ☐ Periapicals/Occlusals: _____
- ☐ Panoramic: _____
- ☐ None available, please take any necessary x-rays
- ☐ X-rays were sent to your office via email or fax (please circle one)

Comments:_____

_____

_____

Thank you for your referral!
Alison Christensen, DDS
Board Certified Pediatric Dentist