REFERRAL FORM

Dr. Bowers

Pediatric Dentist

AMERICAN BOARD OF PEDIATRIC DENTISTRY
BOARD CERTIFIED

Referring Provider/Practice: _____

Patient Name: _____ **Date:** _____

Age of Patient: _____
**Accepting referrals for patients under 10 years old*

Referring Doctor's Telephone Number:

Referring Doctor: _____ _____

Reason for Referral:

- ○ 1st Dental Visit
- ○ Dental Caries
- ○ Extractions
- ○ Patient with Special Healthcare Needs
- ○ Trauma
- ○ Sedation/Anxiety
- ○ Space Maintenance/Management of the Developing Dentition and occlusion
- ○ Other

Radiographs:

- ○ Non Available
- ○ Sent to Us at: dental.imaging@varietycare.org

COMMENTS:

Date of:

Last Exam: _____
Last Cleaning: _____
Last Fluoride Application: _____

Directions for Returning Form to Us:

Scan and send to dental.imaging@varietycare.org; or fax to 405-604-0865

Address: 1025 Straka Terrace, Oklahoma City, OK 73139
Phone: (405) 632-6688

VARIETY CARE HEALTH CENTERS