8870 N. MacArthur Blvd. #A-101
Irving, TX 75063

Today's Date: _____

Patient's Name: _____ DOB: _____

Parent's Name: _____ Phone Number: _____

Referring Office: _____ Phone: _____

X-Rays Taken? NO YES *Please email x-rays with date of service to info@childrensdentaldfw.com.*

Reason for Referral:

Minimally Invasive Therapies

- ☐ Icon treatment
- ☐ Laser Bacterial Reduction
- ☐ Silver Diamine Fluoride
- ☐ Advanced Biofilm Reduction Therapy

Waterlase Adjunct Services

- ☐ Gingivectomy, operculectomy for tooth access
- ☐ Frenectomy
- ☐ Mucocele removal
- ☐ Non-surgical tooth exposure

Dental Care

- ☐ Infant oral exam
- ☐ Restorative treatment with sedation (n20, oral conscious, deep)

Additional Notes:

Thank you for the privilege of working with your patients!

Please visit our website under "Referring Doctors" if you need additional pediatric referral forms or email us to request more forms.

Childrensdentaldfw.com
P: 214-484-3199
Email: info@childrensdentaldfw.com
F: 214-484-3218