



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

Coppell Location  
120 S. Denton Tap Rd. Ste 230  
Coppell, TX, 75019

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 the office.*

Reason for Referral:

- |   |   |
|---|---|
| <input type="checkbox"/> Restorative Treatment              | <input type="checkbox"/> Gingivectomy                       |
| <input type="checkbox"/> Treatment with sedation/anesthesia | <input type="checkbox"/> Frenotomy                          |
| <input type="checkbox"/> Icon (white lesion) treatment      | <input type="checkbox"/> Silver Diamine Fluoride            |
| <input type="checkbox"/> Routine Recall Care                | <input type="checkbox"/> Mucocele/Cold Sore Laser Treatment |
| <input type="checkbox"/> Laser Bacterial Reduction          | <input type="checkbox"/> Other: _____                       |

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.