EST. 2022

HONEY BEE

PEDIATRIC DENTAL CO.

Patient Referral

Patient Name: _____ **DOB:** _____

Parent Name: _____ **Phone:** _____

Reason for Referral:

- Dental Exam
- Decay
- Special Needs
- Trauma
- Sedation/Anesthesia
- Frenectomy

info@kctonguetieco.com

Radiographs:

- None Taken
- Emailed To info@honeybeepdc.com
- Sent With Patient

Comments:

_____

_____

_____

_____

Referring Provider: _____

- TREATMENT ONLY
- ESTABLISH DENTAL HOME

Treatment not guaranteed at consultation visit