OREGON Pediatric Dental Care

Serving Family's Dental Needs in the Willamette Valley

REFERRAL SLIP

Date: _____

Patient Name: _____ DOB: _____

Responsible Party: _____ Phone: _____

Indicate office referring to:

☐ Springfield Kids' ☐ Eugene Kids' ☐ Oregon Family Ortho

For:

- ☐ Treatment of_____
- ☐ Diagnosis _____
- ☐ Other_____
- ☐ The case history is sent to you separately

In regards to:

_____

_____

_____

Radiographs:

☐ None ☐ Sent with Patient ☐ Sent by E-Mail Date E-Mail Sent: _____

Referring: _____ _____ _____

Provider Email Phone

Patient to return to referring doctor? ☐ Yes ☐ No

Springfield Kids Dentist

scheduling@springfieldkidsdentist.com
541-654-4996

EUGENE Kids' DENTIST

scheduling@eugenekidsdentist.com
541-844-1667

Oregon Family Orthodontics

smile@oregonfamilyortho.com
541-359-3261