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Child Referral Form

Patient Information

Full Name:____
Last First M.I. DOB

Address:____
Street Address City State Zip

Home Phone:________________ Cell Phone:________________ Email:____________________

Parent/Guardian Name:____________________________ Phone #____________________

Dental Insurance: ___Y ___N

Requesting Physician's Name & Practice Name:________________________________

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Practice Phone# Practice Fax# Physicians Email

The patient is being referred for the evaluation of the following symptoms

- ○ Grinds Teeth
- ○ Snoring
- ○ Mouth Breathing Day/Night
- ○ Allergic Symptoms
- ○ Restless Sleep
- ○ Frequent Headaches
- ○ Speech Problems
- ○ Tonsillectomy/Adenoidectomy
- ○ ADHD
- ○ Dark Circles Under Eyes
- ○ Nightmares
- ○ Bedwetting

Additional Comments:

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Physician Signature Date