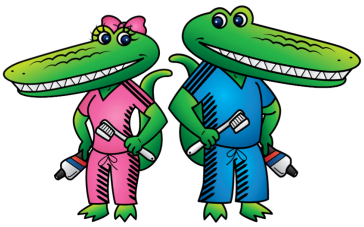

AXELSEN & COBB KID'S DENTISTRY

Vanessa R. Axelsen, D.D.S. | David J. Cobb, D.D.S.

(913) 829-0981 | 975 N Mur Len, Ste A, Olathe, KS 66062 | OlatheKidsDentistry.com

PATIENT REFERRAL FORM

Today's Date: _____/_____/_____ Date patient was evaluated in your office: _____/_____/_____

Patient name: _____ Patient's DOB: _____/_____/_____

Patient address:_____

Parent's name: _____ Parent's phone (home/cell/work):_____

Y | N Dental Insurance If yes, insurance provider: _____

Requested treatment:

☐ Consultation and treatment requested by referring dentist

Treatment requested to be completed: _____

☐ Comprehensive evaluation and any treatment deemed necessary by Drs. Axelsen & Cobb

Upon completion of consultation/treatment:

☐ Return patient to referring dentist for routine care

☐ Retain patient for continued care

Reason for referral (check all that apply):

☐ Behavior/age

☐ Special health care needs

☐ Extensive dental caries

☐ Nitrous oxide sedation

☐ Treatment under general anesthesia

☐ Space maintainer: _____

☐ Pediatric oral surgery (i.e., extractions)

☐ Emergency care

Radiographs: Date radiographs were made: _____/_____/_____

☐ Enclosed

☐ None provided

☐ Patient will bring

☐ Will be sent via: Email | Mail

*To email radiographs, send to **drcobb@sbcglobal.net** and include in email: your office name, phone number, patient name, patient date of birth, and date radiographs were made.*

Additional Comments: _____

_____

_____

Referring dentist: _____

Address: _____

Phone: _____ Email: _____

Please call Axelsen & Cobb Kid's Dentistry to schedule an appointment.