Pediatric Dentistry Referral Form

Phone: 504.894.6778
Fax: 504.896.2704
CHNOConcierge@LCMChealth.org

Patient Information:

Patient Name: ____

Parent/Guardian Name: ____

Patient Date of Birth: ____________________ Phone: _______________________________

Medical History:

____

____

Medications: ____

Allergies: ____

Reason/Concern for Referral:

☐ Fillings - Teeth #'s: ____

☐ Crowns - Teeth #'s: ____

☐ Extractions - Teeth #'s: ____

☐ Pulp Therapy - Teeth #'s: ____

☐ Behavior Management - In office: ____________ General Anesthesia: ____________

Were radiographs obtained? ☐ Yes ☐ NO

If yes, please send radiographs to CHNOConcierge@LCMCHealth.org

Comments:

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Referred By:

Provider: ___________________________

Address: ____________________________

Phone: ______________________________

CHNOLA Dental Clinic

Phone – 504.896.2052

Fax – 504.896.9581