Indianola
PEDIATRIC DENTISTRY

Sandra Fox, DDS
2001 North Sixth Street Indianola, IA 50125
P: 515-808-7000 | F: 515-808-7001
office@indianolapediatricdentistry.com

Patient Name:____

DOB:____________________ Referral Date: _________________

Legal Guardian: ____

Contact Number:____

Referral Reason (check all that apply):

☐ Extent of Treatment Needs
☐ Sedation / General Anesthesia
☐ Special Health Care Needs
☐ Behavior
☐ Age
☐ Trauma

Comments:____
____
____

Radiographs

☐ Yes - Will Be Sent
☐ To Be Taken

Date Made: _______________________
Type: ____________________________

Please email radiographs to office@indianolapediatricdentistry.com and include: office name, patient name, date of birth, and date radiographs were made

Referring Dentist

Dentist Name:____

Office Name:____

Phone:_______________________ Email: _________________________

Please email or fax this form to our office and we will call the family to schedule an appointment. Thank you!