Please Select an Office:

☐ SAGINAW Pediatric Dentistry

705 W. Bailey Boswell Rd.
Saginaw, TX 76085
(817) 232-5997

☐ COLLEYVILLE Children's Dentistry

5708 Colleyville Blvd. Ste. A
Colleyville, TX 76034
(817) 428-8575

Hospital Referral Form- Medicaid Referral #: _____

Date: _____ **Referring Office:** _____ **Referring Doctor:** _____

Child's Name: _____ **DOB:** _____

Sex: ___**M** ___ **F** **Is Child in Pain?** ___**Yes** ___ **No** **X-Rays Taken:** ___ **Yes** ___ **No**

Parent/ Guardian Name: _____

Address: _____ **City/Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Known Medical Conditions: _____

Medicaid/ CHIP MCO: MCNA DENTAQUEST TRADTIONAL

Patient ID #: _____ *(Please send copy with form)* ***PROPOSED***

DIAGNOSED TREATMENT PLAN: Please list all teeth below

O	Composite Fillings:	___	___	___	___	___	___	___	___	___	___	___
O	Extractions:	___	___	___	___	___	___	___	___	___	___	___
O	Pulpotomys:	___	___	___	___	___	___	___	___	___	___	___
O	Crowns:	___	___	___	___	___	___	___	___	___	___	___
O	Sealants:	___	___	___	___	___	___	___	___	___	___	___
O	Frenectomy:	___	___	___	___	___	___	___	___	___	___	___

_____ Other (*please explain*): _____

You may email the referral and X-rays to: melissa.drgober@sbcglobal.net