1145 Aspira Court, Mansfield, Ohio 44906

REFERRAL FORM

FAX to: Playtime Dental **Fax #: 419-775-9339**

or E-mail PDF to: officemanager@playtimedental.com

Date: ______________________________

Referring Practice: __________________________________

Referring Doctor: ____________________________________

Patient's Name: ________________________ **Birthdate:** _______________

Phone: ______________________

Date of last prophylaxis: _______________

TEETH TO BE TREATED:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

R L

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

The above patient is being referred for the following reasons: ________________

___________________________________ ___________________________________

Do you want us to complete all treatment needed? Y N ________________

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If available, e-mail x-rays to officemanager@playtimedental.com. We may still need to take additional x-rays.

We will not schedule an appointment without this referral form.