1145 Aspira Court, Mansfield, Ohio 44906

REFERRAL FORM

FAX to: Playtime Dental Phone # 419-462-9743 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 _____

_____

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.