DR. LULU

PEDIATRIC DENTISTRY

We would like to introduce _____ DOB _____,
who has been seen in our office on_____ and due to:
[ ] age, [ ] amount of work needed
[ ] medical conditions, Please list significant medical conditions and allergies:
_____

We recommend seeing a Pediatric Dentist for a:
[ ] New Patient appointment [ ] Comprehensive Treatment appointment
[ ] Emergency/Limited
Is the patient currently experiencing pain/symptoms [ ] Yes [ ] No
[ ] Radiographs taken [ ] Radiographs not taken

Guardian Name: _____ Phone Number: _____
Referring Doctor:_____
Referring Doctor number: _____ Office email: _____

Please include any radiographs and proposed treatment plans with this referral. Email to info@DrLuluPediatricDentist.com

Thank you for your referral.
We will call the patient to discuss the next steps and update you as the appointment is scheduled and treatment is provided.

SCAN ME

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