ALL STAR DENTAL℠

www.allstardentalclinic.com   Medicaid and most major insurance/PPO's accepted

PEDIATRIC TREATMENT REFERRAL FORM

Parents: After treatment, please return to your primary dentist.

Date: ____/_____/20_____

Introducing: ______________________________

Patient Contact Phone #: (____)______________

Consultation For: ______________________________

Procedures completed at your office within past 6 months:

□ Prophy □ Fluoride □*BW's □*PA's

REFERRING DENTAL OFFICE

Dr's Name: ______________________________

Office Name: ______________________________

Office phone #: (______)______________

Street Address: ______________________________

City: __________________ State: ____ ZIP: ________

*Please email X-rays to us with patient's name and date of appointment.

LABIAL

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

LINGUAL

T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

LABIAL

□ 2316 W. Madison St. Chicago, IL 60612 • 312.491.0601
madison@allstardentalclinic.com

□ 2239 W Jefferson St. Suite #104A-105B Joliet, IL 60435 • 815.207.4442
joliet@allstardentalclinic.com

□ 12121 Western Ave. Suite #3 Blue Island, IL 60406 • 708.293.7773
blueisland@allstardentalclinic.com

□ 5644 W. Roosevelt Rd. Chicago, IL 60644 • 773.473.8888
roosevelt@allstardentalclinic.com

□ 1261 N. Lake St. Suite #J, Aurora, IL 60506 • 630.801.0002
aurora@allstardentalclinic.com

PED1