REFERRAL

Healthy Smiles Start Here!

Cove Pediatric Dentistry & Orthodontics

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To refer a patient for a consultation, please complete the form below. This form may also be accessed and submitted via our website, CovePDO.com. Your patient can contact our office and set a convenient appointment time. We will keep you informed of the patient's treatment plan and progress.

Referral Date _____

Referring Doctor _____

Patient's Name _____

Date of Birth _____

Parent's Name _____

Best Phone # _____

E-mail _____

In order to best serve your family, we are referring you to a specialist.

☐ Pediatric Dental Referral ☐ Orthodontic Referral

Special concerns for this patient: _____

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Thank you for your referral. We will request additional information as needed.

Please send this referral form to our secure, private fax: 254-238-5233.