Lockhart Pediatric Dentistry
100 Brandon Road, Suite W
Starkville, MS 39759

Referral Form

Referring Doctor: _____ Office Phone: _____

Patient Name: _____ DOB:_____ Age:_____ Gender: _____

Insurance Coverage: _____ Insurance ID:_____

Guardian Name: _____ Phone: _____

Guardian Email: _____ Address:_____

Disabilities & Medical Conditions: _____

Date of exam in your office: _____ Was the patient cooperative? Y N

What type of exam did your office perform? Thorough or Partial

If prophylaxis and/or fluoride tx were performed, please list date of service: _____ Cooperative? Y N

Were radiographs taken? Y N If yes, please list date and type: _____

Circle noted carious areas: URPost ULPost LLPost LRPost UAnt LAnt

Was dental treatment attempted in your office? Y N Is the patient in pain? Y N Is there infection? Y N

Please list any prescribed medications: _____

Additional notes: _____

Please send digital copies of radiographs to office@huxlock.com. Thank you!