Referral to Graduate Pediatric Dental Clinic

University of Michigan School of Dentistry
1011 N. University Ann Arbor, Michigan 48109-1078
734-764-1523
734-615-7294 FAX

Child's Name: _____

Radiographs Enclosed: _____ **DOB:** _____

Radiographs Attained: _____

CONTACT: _____
(Parent/Guardian's Name)

_____ **Dental Insurance:** _____
(Address)

_____
(City) (Zip)

_____
(Area code and Telephone Number)

PLEASE EMAIL ALL XRAYS TO dentalrecordcopy@umich.edu with name and date of x-ray
****Please do NOT fax x-rays****

Please circle approximately how many cavities 2 4 6 8 or more

DENTAL CONDITIONS: _____

_____

BEHAVIOR OF THE CHILD: _____

_____

MEDICAL CONDITIONS: _____

_____

ALLERGIES: _____

MEDICATIONS: _____

PLEASE COMPLETE ALL INFORMATION OR FORM WILL BE RETURNED.

- **THE PARENT WILL BE ADVISED TO RETURN TO YOUR OFFICE FOR EMERGENCY CARE UNTIL WE HAVE PERFORMED A THOROUGH EXAM AND TREATMENT PLAN AND REGISTERED THE PATIENT IN ONE OF OUR CLINICS.**

SIGNATURE: _____ **DDS** **DATE:** _____

PRINT YOUR NAME: _____ **DDS** **TELEPHONE:** _____

ADDRESS, CITY, ZIP: _____ **FAX** _____