Pediatric Dentists:
Brent J. Bradley, DDS*
Kelli J. Jobman, DDS*
Karli M. Williams, DDS*
Stephany P. Liu, DDS
General Dentist:
Carla L. Heino, DDS
(*Owner)

Patient Referral Form

Date: ______________________________

Introducing: ______________________________ DOB: ______________

Parent / Guardian Name: ______________________________

Phone Number: ______________________________

Xrays:

- o Mailed
- o Emailed to info@bhpdsd.com
- o Sent with patient
- o To be taken on arrival

Please choose one:

- o Please complete treatment and return to our office for routine care
- o Please complete treatment and routine care

Comments: ______________________________

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Referring Doctor's Name: ______________________________

Phone Number: ______________________________

- o Please mark if you would like a call from the Pediatric Dentist after the exam

RIGHT	Please evaluate the following teeth (please circle)																LEFT
	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				
				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	

700 Sheridan Lake Road, Rapid City, SD 57702 | Phone: (605) 341-3068 | Fax: (605) 341-5757

Email: info@bhpdsd.com | Website: bhpediatricdentistry.com