

Children's Hospital Boston
Department of Dentistry
300 Longwood Ave. Mailstop: HU-226
Boston, MA 02115
Main #: (617) 355-6571 Option 3 Fax #: (617) 730-0478

Please complete all of the fields below to help expedite this request.

Child's Name: _____

Child's Date of Birth: Month: _____ Day: _____ Year: _____

Parent /Guardian's Name: _____

Parent /Guardian's Address: _____

Parent / Guardian's Phone #: _____

Has this child ever been to Children's Hospital, Boston? Yes No

If yes, has the child ever been to Children's Hospital Boston, Department of Dentistry? Yes No

Name of Referrer: _____

Referring Doctor (if applicable): _____

Referring Office/Site: _____

Head Start Physician Dentist Other _____

Address: _____

Phone # _____ Fax # _____

Why are you referring this child to Children's Hospital? Please be very specific (i.e. behavior, medical condition, etc.).

Are there any special medical conditions we should be aware of? Yes No

If yes, please explain: _____

Does the parent or guardian speak English? Yes No

If No, what is the primary language? _____ Interpreter needed? Yes No

Have a prophylaxis and/or fluoride treatment within the past 6 months? Yes No

Have x-rays been taken? Yes No

If yes:

- List the date x-rays were taken: _____
- List what x-rays were taken: _____
- Please send x-ray with patient to the appointment.