

Patient Referral Intake Form



Thank you for referring your patient to Boston Children's Department of Dentistry. We accept new patients 16 years old and younger.

For an urgent consult, please call 617-355-6571. Urgent referrals will be evaluated on a case-by-case basis.

Non-urgent consults are scheduled seven to eight months out after receiving the patient's X-rays and the last clinical note.

(HIPAA does not require you to obtain parental authorization to release your patient's information.)

For referrals for minimal (conscious) sedation or general anesthesia, we request your office:

- attempt restorative treatment with nitrous oxide 2x for children who are healthy (with non-contributory medical histories) and are four or older
- submit a physical exam note, written in the last 12 months, from the patient's pediatrician

Patient information

Date: _____

First name: _____ Last name: _____

Date of birth: _____ Gender: M F Non-binary

Parent/Guardian name: _____

Relationship to patient: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian phone: _____

Email address: _____

Preferred language: _____ Interpreter needed? Yes No

Referrer information

Referring office: _____

Referring dentist: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Primary care physician: _____

Phone: _____ Fax: _____

Date of last physical: _____

Insurance information

Dental insurance: _____ State issued: _____

Subscriber ID: _____ Group number: _____

Subscriber name: _____ Date of birth: _____

Medical insurance: _____ State issued: _____

Subscriber ID: _____ Group number: _____

Subscriber name: _____ Date of birth: _____

Patient care information

Reason patient is being referred to Boston Children's (check all that apply):

- Transfer of care Second opinion Behavioral Medically complex
- Endodontic treatment, teeth #: _____
- Extractions, teeth #: _____
- Orthodontic treatment Periodontic treatment
- Pediatric dental treatment Prosthodontic treatment
- Minimal (conscious) sedation* General anesthesia*

*Submit physical note from pediatrician or family physician.

For the following, refer patient to Plastic & Oral Surgery, 617-355-7252

- Lip/Tongue tie TMJ concern
- Permanent teeth extractions only, including wisdom teeth

Pertinent medical history: _____

Date of last cleaning: _____

Date of last X-ray: _____

Completed Attempted, but not successful Not attempted

Does patient need antibiotic prophylaxis? Yes No

Has the patient had two or more unsuccessful attempts of treatment with nitrous oxide or sedation?

Yes, dates: _____

No Not applicable

Summary of treatment needed (Include tooth number and surfaces):

Email this completed form

Send to dentalreferrals@childrens.harvard.edu and include:

- Patient's name and date of birth in the subject line
- Referral letter
- All supporting documents
- Guardianship paperwork for patients over the age of 18 seeking non-orthodontic services due to a medical condition