Sunny Smiles

DENTISTRY FOR CHILDREN & YOUNG ADULTS

PATIENT REFERRAL

Please complete all applicable fields

Use this form to refer a child or young adult for pediatric dental care.

Fields marked * are required

REFERRING PROVIDER

Referring Doctor Name *

Clinic Name *

Clinic Address *

Clinic Phone *

Clinic Email *

PATIENT INFORMATION

Patient Name *

Date of Birth *

Age

Parent / Guardian Name *

Parent / Guardian Phone *

Parent / Guardian Email

Preferred Location * ☐ Oxnard ☐ Ventura

Preferred Language (if known)

REFERRAL DETAILS

Select all that apply.

- ☐ Dental exam / consultation
- ☐ Cleaning / preventive care
- ☐ Toothache / dental pain
- ☐ Dental injury / trauma
- ☐ Restorative treatment
- ☐ Extraction consultation
- ☐ Sedation consultation
- ☐ Special health care needs
- ☐ Other

If other, please specify

CLINICAL NOTES

Reason for referral, symptoms, relevant history, and any requested follow-up

RECORDS & TIMING

Records included (check all that apply)

- ☐ Radiographs
- ☐ Dental records
- ☐ Relevant medical history
- ☐ Other

X-RAY FILES & ATTACHMENTS

- ☐ Files attached with referral
- ☐ Sent separately using secure method

File names / dates

Timing ☐ Routine ☐ Urgent - please contact referring office

Referring Provider Signature *

Date *

SECURE RETURN Please use your office's approved secure method to send this form and records.

For urgent concerns, call the selected location. Avoid sending patient information through unsecured email.

Oxnard: 805-436-0280 | Ventura: 805-644-5516

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