All·Kids·Dental
PEDIATRICS & ORTHODONTICS

Referral Form to use by community dentist when

Referring to All Kids Dental

(Fill out and send to records@akdsmiles.com **with dental x-rays**)

Practice/clinic name: _____

Referring Dentist's name: _____

Best Phone Number to reach the provider making this referral: _____

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Parent/ Guardian Date of Birth: _____

Contact Phone: _____

Insurance Company: _____

Group/ Medicaid Number: _____

Subscriber ID: _____

Reason for Referral: _____

Caries on Teeth#: _____

Pulp therapy on Teeth #: _____

Behavioral Concerns

- ☐ **Pre-cooperative behavior**
- ☐ **Need for conscious sedation**
- ☐ **Need for general anesthesia**
- ☐ **Other** _____

Office Preference

- ☐ **Glenwood Springs**
- ☐ **Eagle**
- ☐ **Rifle**

GLENWOOD SPRINGS
970.928.9500
2624 Grand Ave., Suite 200
Glenwood Springs, CO 81601

EAGLE
970.328.9500
1185 Capitol Street, #101
Eagle, CO 81631

RIFLE
970.625.9500
900 Airport Road, Suite 5
Rifle, CO 81650

ASPEN
970.925.2798
204 W. Hyman Avenue
Aspen, CO 81611