125 SW Military Drive
San Antonio, Texas 78221
Phone: 210-922-3483
Email to: schedule@sscdc.org
Fax: (210) 610-5887

Referral Form

Patient's Information:	Referring Office Information:
Patient Name:	Office Name:
DOB:	Office Location:
Parent/ Legal Guardian:	Doctor's Name:
Phone:	Phone:
Email:	Email:

Reason for Referral:

PEDIATRIC DENTAL

☐ Treatment with General Anesthesia

(The following are indications for General Anesthesia: Pre-cooperative ages 2 or 3, Lack of cooperation, Extensive treatment necessary, Failed Sedation/Treatment, Development disability/delay.)

☐ Treatment with Oral Sedation

(The following are indications for Conscious Sedation: Fearful/Anxious patient for whom basic behavior guidance techniques have not been successful. Usually children ages 4 and above with fewer teeth that need to be treated, and who can cooperate for treatment in the office.)

☐ Other: _____

Teeth to be treated: _____

If X-Rays have been taken, please enclose with the referral form or email before treatment: schedule@sscdc.org

Referring Doctor's Name: _____ **Date:** _____

We are grateful for your confidence in our practice and understand that your patients are important. All patients will be instructed to return to their regular dental home for their routine check-ups once treatment is completed. Thank You!