Texas Dental Center

9801 Bissonnet St Ste K Houston, TX 77036
Phone: (832) 831-9101
Fax: (832) 831-4394

Please Fax this Referral form to : (832) 831-4394 or
Email to info@texasdentalcenter.com

Patient Name _____ Age _____

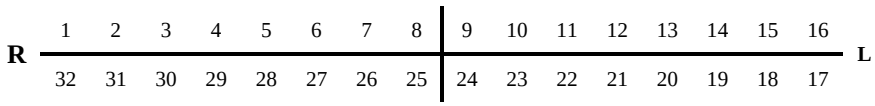
Phone: Home ( ) _____ Cell Phone: ( ) _____

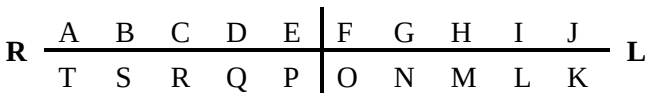
Parent's Name: _____

Special Health Concerns: _____

Reason for referral

- ☐ Pain
- ☐ Trauma
- ☐ Special Needs
- ☐ Rampant Caries
- ☐ Behavior/Age
- ☐ Extractions
- ☐ IV Sedation
- ☐ Interceptive orthodontic treatment





Other _____

Referring Doctor information

☐ X-rays Given to Parent ☐X-rays mailed/E-mailed ☐Needs X-rays

Referring Doctor: _____ Phone: _____

Doctor's Email address: _____

Today's Date: _____