



REFERRAL FORM

Cupid Pediatric Sedation Dentistry

Sandra Oh, DMD

Board Certified Pediatric Dentist
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Suwanee, GA 30024

770-679-8563

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Please email form to: Referrals@cupidpsd.com

Patient inquiries to: Info@cupidpsd.com

Today's Date: _____

Patient Name _____ DOB ____ / ____ / ____

Allergies / Medical Conditions _____

Parent 1 _____ DOB ____ / ____ / ____ Relationship _____

Email _____ Cell _____

Street Address _____

City _____ State _____ Zip _____

Parent 2 _____ Phone _____ Relationship _____

Primary Insurance _____ Member ID _____

Secondary Insurance _____ Member ID _____

Reasons for Referral:

- Extreme Anxiety/Fear
- Behavior Management
- Autism
- ADD/ADHD
- Failed N2O
- Failed Oral Conscious Sedation
- Failed IV Sedation
- Medically Challenged
- Mentally Challenged
- Extensive Treatment
- Other: _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
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I			A	B	C	D	E	F	G	H	I	J			E	
G			T	S	R	Q	P	O	N	M	L	K			F	
H															T	
T																
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Referring Doctor Information

Practice / Doctor Name _____

Address _____

Phone _____ Email _____

Please Include the following:

- Treatment Plan
- Copies of X-rays or specify if unable to take
- Relevant Clinical Notes

Thank you for your referral!

We are honored to be a part of your patient's dental care.