



**Walnut Creek Pediatric Dentistry**  
**Dr. Barry Webber, DDS**  
**10983 Cumberland Dr.**  
**Papillion, NE 68046**

## **Patient Referral Form**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Parent's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Referring Doctor/Practice: \_\_\_\_\_ Date Referred: \_\_\_\_\_

X-Rays: ☐ Given to patient ☐ Sent via mail ☐ Sent via email ☐ New x-rays needed  
 Date of last panoramic film: \_\_\_\_\_

### **Referred for (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Space Maintainers   | <input type="checkbox"/> Pediatric Surgery (e.g. Frenectomy, extractions) |
| <input type="checkbox"/> Sedation            | <input type="checkbox"/> Restorative                                      |
| <input type="checkbox"/> High Anxiety        | <input type="checkbox"/> Pulp Therapy                                     |
| <input type="checkbox"/> Pre-cooperative Age | <input type="checkbox"/> Other (Please describe in remarks section below) |
| <input type="checkbox"/> Oral Habits         |   |

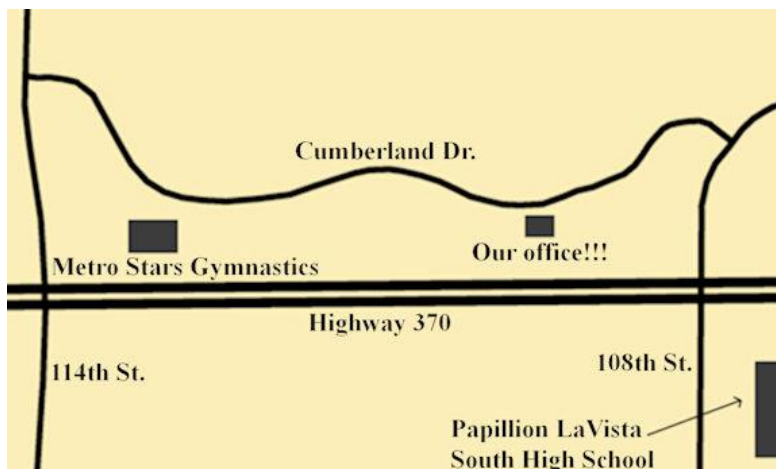
### **Teeth To Be Treated:**

R   1   2   3   4   5   6   7   8   9   10   11   12   13   14   15   16   L  
      32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

R   A   B   C   D   E   F   G   H   I   J   L  
      T   S   R   Q   P   O   N   M   L   K

**Remarks:** \_\_\_\_\_  
 \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



### **Contact Information:**

Tel: 402-590-2018  
 Fax: 402-590-2019  
 Email:  
 walnutcreekteeth@gmail.com

### **Hours of Operation:**

Mon-Thurs: 8am-12pm, 1:30pm-5pm  
 Friday: 8am-12pm

### **Visit us online:**

[www.walnutcreekteeth.com](http://www.walnutcreekteeth.com)