Smile Kingdom

General Dentistry
Infants, Children and Teens

Date: _____ Referring Doctor: _____

Referral Patient: _____ Address: _____

Patient Phone: _____ _____

Phone: _____

REFERRAL FOR DENTAL CARE

❑ Did not attempt to treat in office/prefer child to be seen at Smile Kingdom

❑ Attempted to treat in office/ prefer child to be seen at Smile Kingdom

❑ Child may need sedation/anesthesia

X-RAYS: ❑ Emailed ❑ Take X-rays

PRIMARY DENTAL CONCERNS: _____

_____

_____

_____

2340 Sunrise Blvd., Suite 25
Rancho Cordova, CA 95670
(Located in the Rivergate Shopping Center)

(916) 852-8510
www.smilekingdom.com
frontoffice@smilekingdom.com