Boston Pediatric Oral Health Center
100 East Newton Street, 1st Floor
Boston, MA 02118
Patient Referral Form

Please fax form to: 617.638.5033 or email to: gsdmpedo@bu.edu

Patient Name:_____ Tel:_____

Referring Provider:_____ Tel:_____

Patient address: _____

_____

Health Insurance:

Dental _____

Policy # _____

Referred patient may require:

____Dental Rehabilitation under general anesthesia in the operating room

____Root canal therapy **Tooth #____**

____Orthodontic treatment

____Oral Surgery **Tooth #____**

____Oral Sedation

____Extraction **Tooth #____**

____Panograph

____TMD Evaluation

____Other_____

Comments: