Rimrock Pediatric Dentistry

TRAILHEAD PEDIATRIC DENTISTRY

BEARTOOTH PEDIATRIC DENTISTRY

GLASGOW PEDIATRIC DENTISTRY

P: 406-248-3303 **Email:** referral@backbonedental.com

Referring Dentist: _____ **Phone** _____

Please complete form in its entirety.

Childs Name _____ **DOB** _____ **Age** _____

Guardian _____ **Relationship**_____ **DOB** _____

Address _____

Preferred Number _____

Primary Dental Insurance _____

Policy Holder _____ **DOB** _____ **Employer** _____

Subscriber ID _____ **Group Number** _____

Medicaid ID _____

Chip/ACS ID _____ **Amount Billed to Insurance** _____

Secondary Insurance _____

Completed Treatment (Please include date completed)

___ Prophy ___ Fluoride ___ Bitewings ____ Occl ___Pano ____ Limited Exam ____ Other

Please send treatment plan or please note general caries

Recommendation Circle One: Operative (N20) Oral Sedation IV Sedation

Notes: