



Providing Pediatric & Adult dentistry to those who have Medicaid and uninsured residents of Virginia

Piedmont Regional Dental Clinic

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PATIENT REFERRAL

Introducing: _____

Appointment Date & Time: _____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

Please call **540-661-0008** to Schedule an Appointment

This patient is being referred for evaluation of the following:

- ☐ Caries/Decay
- ☐ Dental Development
- ☐ Gum disease
- ☐ Fractured Tooth or dental trauma
- ☐ Missing Teeth
- ☐ Orthodontic Evaluation
- ☐ Other _____

Comments: _____

☐ Please call me before proceeding with treatment

☐ I have sent radiographs for your evaluation

☐ Please send additional referral pads

Referring Dr: _____

Date: _____ Phone # _____