SWEET TOOTH
Pediatric Dentistry

EFFECTIVE 06/01/2026

Due to our current patient volume, we are operating at maximum capacity and must prioritize access for our existing patients.

THE MAXIMUM AGE FOR PATIENTS REFERRED FOR TREATMENT IS 10 YEARS OLD.

AGE LIMITATION DOES **NOT APPLY TO PATIENTS WITH SPECIAL NEEDS**

REFERRAL

PATIENT INFORMATION

CHILD NAME:_____ DOB:_____

PARENT/LEGAL GUARDIAN NAME:_____

CONTACT NUMBER: _____

DENTAL INSURANCE CO.:_____ ID NUMBER: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

REFERRAL INFORMATION

REFERRING DR. NAME: _____ OFFICE NAME: _____

REASON FOR REFERRAL:_____

_____

_____

_____

PLEASE COMPLETE THE FOLLOWING FOR OUR MUTUAL PATIENT:

☐ COMP EXAM ☐ LIMITED EXAM/TX ☐ TAKE X-RAYS ☐ X-RAYS FROM __/__/__ ARE BEING SENT

phone 715.214.1234

fax 715.214.1235

email Referrals@sweettoothkidsdentistry.com

location

311 Financial Way Ste. 200

Wausau, WI 54401

NEED A CORRESPONDENCE LETTER FOR THIS PATIENT?

Please send any requests to Brittany@sweettoothkidsdentistry.com