

Acorn Dentistry for Kids Referral Form

Phone: 503.874.4560 Fax: 503.874.4562
referral@acorndentistryforkids.com
www.acorndentistryforkids.com

Patient First & Last Name _____
Patient Date of Birth _____
Patient Diagnosis **Please complete all treatment deemed necessary**

Today's Date _____
Parent/Legal Guardian Name _____
Phone Number _____
Email _____
Home Address _____

Please select all that apply

- X-rays taken
- X-rays sent with patient
- X-rays sent to referral@acorndentistryforkids.com
- Please accept patient into pediatric practice
- Patient to return to referring office

Insurance Information

All Private insurance & Oregon Health Plan accepted.

- Patient does not have dental insurance
- Patient has Oregon Health Plan **OHP ID Number** _____
- Patient has private dental insurance
Insurance Company _____
Subscriber First & Last Name _____
Subscriber Date of Birth _____
Subscriber ID # _____
Group # _____

Acorn Dentistry for Kids Locations

Please select the location closest to the patient's home address

- Silverton** 411 N Water Street, Silverton, OR 97381
- Keizer** 4817 River Rd N, Keizer, OR 97303
- Corvallis** 1731 NW Kings Blvd, Corvallis, OR 97330
- Hillsboro** 434 S 1st Ave, Suite 300, Hillsboro, OR 97123
- West Salem** 1049 Edgewater St NW, Suite 100, Salem, OR 97304
- East Salem** 799 Lancaster Dr NE, Suite 140, Salem, OR 97301

Referral Information

Referring Office _____
Referring Doctor Name _____

Referring Office Phone # _____
Referring Office Email _____

