briargate

pediatric dentistry | orthodontics

James Busch, DDS – Pediatric Dentist

INFANT FRENECTOMY REFERRAL

Date: _____

Baby's Name: _____ Baby's DOB: ___/___/___

Mother's Name: _____

Home Phone Number: _____

May We Call? ☐ YES ☐ NO

REFERRED BY

Lactation Consultant: _____

Physician/HCP: _____

Phone: _____ Email: _____

Reason For Referral: _____

CONSULTATION FOR

☐ Upper Lip Frenectomy ☐ Tongue Frenectomy

☐ Other (please explain) _____

Special Instructions: _____

_____

3466 Briargate Blvd | Colorado Springs, CO 80920
Phone: 719-260-1600 | FAX: 719-260-1640
www.BriargatePediatricDentistry.com

For patients planning to have infant frenectomy on the same day as the consultation, please call ahead to verify that our office has all dental insurance information needed.