Children's Dental Columbia

Heather H. Owens, D.D.S.
Gina H. Carney, D.M.D.
Katherine H. Bolding, D.D.S.

Patient Name _____ DOB:___/_____/_____

Parent/Guardian Name _____ Phone: _____-_____-_____

Parent Email:_____

Dental Insurance:_____

Reason for referral: Please check all that apply:

☐1st Visit ☐Age/behavior ☐ Trauma/Emergency/Toothache ☐Restorative Only
☐Extractions ☐ Oral Sedation ☐Hospital Case ☐ IV Sedation ☐Special Needs

Procedures Completed:

Exam Date: _____
Prophy Date: _____
Fluoride Date: _____

X-rays taken:

Panoramic Date:_____
BWX Date:_____
Periapical Date:_____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
				A	B	C	D	E	F	G	H	I	J		
				T	S	R	Q	P	O	N	M	L	K		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Notes:_____
_____
_____

Referring Doctor: _____ Date: ___/___/_____

☐ Doctor requests phone consultation

Please email this completed form, current treatment plan and x-rays. Thank you!

6000 Trotwood Ave
Columbia, TN 38401
Phone: 931-381-9721
Fax: 931-381-3507
Email: info@ChildrensDentalColumbia.com

Office Hours:
Monday-Thursday
8-5pm (Lunch 12-1pm)
Friday 8-12pm

In Network Insurances: Delta Dental, BCBS, UHC, UMR, Cigna, and some plans GEHA-Connection Dental

Not currently accepting TNCARE Medicaid or TNCOVERKIDS