



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:

X-rays taken:

Exam Date: _____

Panoramic Date: _____

Prophy Date: _____

BWX Date: _____

Fluoride 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

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