



## General Dentistry for Youth

first tooth through age 20




### Dental Referral Form

Introducing \_\_\_\_\_ Age \_\_\_\_\_

Patient Phone \_\_\_\_\_ Date \_\_\_\_\_

Referring Office \_\_\_\_\_ Office Phone \_\_\_\_\_

Reason for Referral:

-  1st Dental Visit
-  Toothache
-  Caries/Decay
-  Special Needs
-  Trauma
-  Hospital Dentistry

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please evaluate the following teeth (please circle)

	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16		
RIGHT				A	B	C	D	E		F	G	H	I	J					LEFT
				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		

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