



## General Dentistry for Youth

first tooth through age 20

### Dental Referral Form

Date \_\_\_\_\_

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

Referred from \_\_\_\_\_

- Reason for Referral
- 1st Dental Visit
  - Toothache
  - Caries/Decay
  - Special Needs
  - Trauma

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					K L M N O				P Q R S T				
	32	31	30	29	28	27	26	25			24	23	22	21	20	19	18	17

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