Smile Starters

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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