



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
R			A	B	C	D	E	F	G	H	I	J			L
I															E
G			T	S	R	Q	P	O	N	M	L	K			F
H															T
T															
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

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