



# 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 I G H T	A B C D E							F G H I J					L E F T		
	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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