Smile Starters

# 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 | | | 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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