REFERRA PADS
5" X 7"

Children's Dentistry

Where Healthy Smiles Start

Date _____

Patient Name _____ Age _____

Referring Doctor _____

Referring Doctor Phone Number _____

Reason for referral ☐1st Dental Visit ☐Toothache ☐Decay ☐Special Needs ☐Trauma ☐Sedation/ Anesthesia

Radiographs ☐None available ☐Emailed

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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