

Website: www.DentistryForKids.com

Practice limited to infants, children, and adolescents

PLEASE SEND THIS REFERRAL WITH THE PATIENT FOR FAX/EMAIL TO OUR OFFICE

Name of Patient: _____ Age: _____ Date: _____

Referring Dentist Name: _____

Referring Dentist Phone: _____

Reason for referral (check all that apply):

- Consultation and Limited Treatment (return to referring dentist for remaining treatment)
- Comprehensive Consultation (complete any and all treatment)
- Establish Dental Home

Special Concerns (check all that apply):

- Behavior/Age
- Dental Trauma
- Special Needs
- Pulpotomy/Pulpectomy
- Crowns/Fillings
- Other: _____
- Extractions
- Infection/Abscess

- Radiographs Required
- Radiographs Taken: emailed to info@dentistryforkids.com



Please evaluate the following teeth (please circle)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A	B	C	D	E	F	G	H	I	J						

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

