Bright Stars Shining Smiles

ToothStars

Pediatric Dentistry & Orthodontics

Doctor Referral Form

Date _____

Patient Name _____ Date of Birth _____

Referring Doctor _____

Referring Doctor Tel. No. _____

Reason for Referral: ☐ 1st Dental Visit ☐ Toothache ☐ Dental Caries

☐ Special Needs ☐ Orthodontics ☐ Nitrous ☐ General Anesthesia

☐ Other – Please Specify _____

Radiographs: ☐ None Available ☐ X-Rays sent with patient

Special Notes _____

_____

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