Four Ever Smile™
Patient Referral Form

Practice Name _____

Practice Address _____

Practice Phone Number _____

SPECIALTY REFERRAL TO:

Introducing:

Parent/Guardian:

Birthdate:

Address:

Telephone:

REFERRED BY DOCTOR:

REASON FOR REFERRAL: ☐ Consultation ☐ Treatment

Please provide specialist with appropriate details of problem (i.e. urgency, areas of concern):

RELEVANT HISTORY (Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.):

☐ An appointment has been made:

Call referring doctor before treatment: ☐ Yes ☐ No

Radiographs: ☐ sent with patient ☐ mailed/transmitted ☐ attached ☐ none available

☐ Please provide written report.

SIGNED: _____ DATE:

Permanent Teeth

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Deciduous Teeth

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K