

**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 ☐ NoRadiographs: ☐ 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

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**Four Ever Smile™**
Replace Teeth Permanently