



General Dentistry for Youth






first tooth through age 20

Dental Referral Form

Date _____

Introducing _____ Age _____

Referred from _____

- Reason for Referral
-  1st Dental Visit
 -  Toothache
 -  Caries/Decay
 -  Special Needs
 -  Trauma

Comments _____

Please evaluate the following teeth (please circle)

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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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