SMILE CREATIONS DENTAL

Adults and Kids Dentistry

Date: _____

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INTRODUCING (PATIENT INFORMATION)

Patient Name: _____ **Phone:** _____

Referred By: _____ **Phone:** _____

Email: _____

REASON FOR REFERRAL

[ ] Comprehensive Exam / Cleanings

[ ] Pediatric Care

[ ] Dental Pain and/or Oral Lesions

[ ] Crowns and/or Implant Crowns

[ ] Dentures - Full and/or Partial

[ ] Extractions and/or Restorations

[ ] Invisalign

[ ] Other: _____

COMMENTS / SPECIAL INSTRUCTIONS

PLEASE CIRCLE AREA OF CONCERN (UNIVERSAL TOOTH NUMBERING)

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

Referring Doctor Signature: _____ Date: _____