



Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Referring Provider Phone: \_\_\_\_\_

#### Reason For Referral

- ☐ First Dental Visit | Hygiene
- ☐ Restorative Treatment | Decay
- ☐ Sedation | General Anesthesia
- ☐ Extraction
- ☐ Dental Trauma
- ☐ Special Health Care Needs

#### Radiographs

- ☐ None Taken
- ☐ Emailed to [referrals@aurorakids.dental](mailto:referrals@aurorakids.dental)

Additional Comments | Concerns: \_\_\_\_\_

Please evaluate the following teeth (please circle)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R				A	B	C	D	E	F	G	H	I	J		L
I															E
G															F
H				T	S	R	Q	P	O	N	M	L	K		T
T															
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17