MIGHTY SMILES DENTISTRY

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REFERRAL FORM

**we see children under the age of 18, patients with special needs of any age

Name: _____

Age: _____ Date: _____

Referring Dr./Referring Office: _____

Referring Dr. Tel. No: _____

Special Concerns: _____

_____

_____

Reason for Referral
- ◯ 1st Dental Visit
- ◯ Toothache
- ◯ Cavity
- ◯ Special Needs
- ◯ Trauma
- ◯ General Anesthesia

Radiographs
- ◯ None available
- ◯ Emailed to xray@mightysmileslv.com

Please evaluate the following teeth (please circle)

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

THANK YOU FOR YOUR REFERRAL.

We appreciate your trust in allowing us to be a part of your patient's dental care.