Patient Referral Form

Date:_____

Child's Name:_____ Phone:_____

Parent's Name:_____

X-rays: ☐ Patient will bring ☐ Are being sent via mail ☐ Please take
☐ Are being sent via email (admin@behindthesmile.com)

Primary teeth:

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

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

Remarks:

_____

_____

_____

Referring Doctor:_____

Phone Number:_____

Address:_____

City:_____ Zip:_____

Please email any x-rays to: admin@behindthesmile.com
Thank You!