Special Smiles

Comprehensive dental care for persons with special needs

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www.specialsmilesltd.com

SPECIAL SMILES REFERRAL

PATIENT NAME: _____ **DOB:** _____

FACILITY/HOME: _____

ADDRESS: _____

_____

PHONE/FAX: _____

REASON FOR REFERRAL FOR TREATMENT UNDER GENERAL ANESTHESIA:

_____

TEETH TO BE WORKED ON (IF APPLICABLE):

			A	B	C	D	E	/	F	G	H	I	J			
Patients Right	1	2	3	4	5	6	7	8	/	9	10	11	12	13	14	15	16
Patients Left																	

_____

32	31	30	29	28	27	26	25	/	24	23	22	21	20	19	18	17
			T	S	R	Q	P	/	O	N	M	L	K			

RADIOGRAPHS:

❑ Please take/send copy ❑ Patient will bring copy ❑ Copy to be sent via email

REFERRING DENTIST'S RECOMMENDATIONS: _____

_____

_____

❑ RETURN TO REFERRING DENTIST **❑ REMAIN AT SPECIAL SMILES**

DENTIST (PRINT): _____

DENTIST (SIGNATURE): _____

ADDRESS: _____

_____

PHONE: _____ **FAX**: _____

EMAIL: _____

DATE: _____

IMPORTANT INFORMATION: When referring a "new patient" to Special Smiles please be sure to have the caregiver/guardian take a copy of the referral form with them. This form is required when they complete our "New Patient Intake/Health History" form on-line at www.specialsmilesltd.com. Referrals should not be sent directly to Special Smiles for new patients.