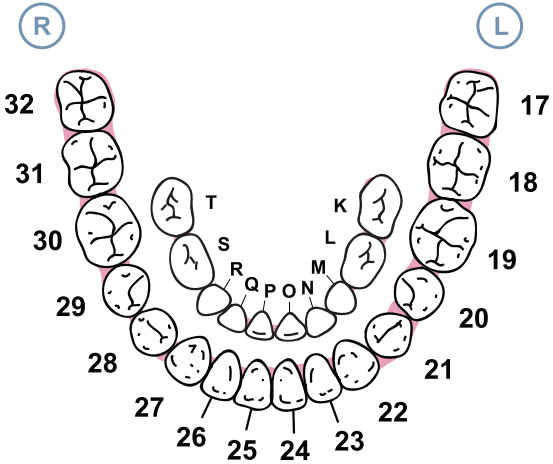
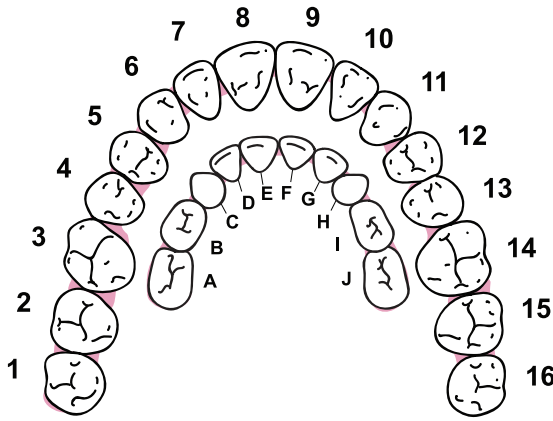




Children's Dental • Orthodontics • Endodontics

REFERRAL FORM



SACRAMENTO 916-374-7711 3433 Arden Way

FOLSOM 916-984-0304 2190 E. Bidwell Street

EL DORADO HILLS 916-941-0303 3840 El Dorado Hills Blvd., #203

ELK GROVE 916-271-3737 9585 Laguna Springs Dr., #120

ROCKLIN/ROSEVILLE 916-380-0102 6000 Fairway Drive, #8

AUBURN 530-368-3685 500 Auburn Folsom Rd., #330

www.makeasmile.com

Fax (all offices): 916-983-9012

Date: ___/___/___ Introducing: _____ Age: _____ DOB: ___/___/___

Parent/Guardian: _____ Phone: (____) _____

Patient Address: _____ Insurance: _____

Referred by: _____ DMD/DDS Insurance ID#: _____

Office Phone: (____) _____

Date Last Exam/X-Ray: _____

Radiographs Enclosed or sent Patient will bring None taken

Referring to Pediatric Specialist Behavior/Age Special Needs

Referring to Orthodontist

- Crowded teeth Deep overbite Impacted tooth Protruded teeth Upper jaw forward or lower jaw
 Spaced teeth Retruded teeth Cross-bite Facial growth problems Lower jaw forward of upper jaw
 Missing teeth Midline discrepancy Open-bite Narrow dental arches Alignment needed for crown/bridge

Overbite: _____% Overjet: _____% Parents concerned: yes no

Referring to Endodontist RCT# _____ Pulp Exposure Periapical radiolucency present

Additional Comments: