PATIENT REFERRAL

ODESSA OFFICE

406 N 4th St Suite A
Odessa MO 64076

treetopdentistry.com

Date: _____

Patient Name _____ Age _____

Referring Office/Doctor _____

Referring Office/Doctor Phone _____

Significant Medical Conditions _____

Reason for Referral

- ☐ 1st Dental Visit
- ☐ Toothache
- ☐ Decay
- ☐ Trauma
- ☐ Sedation/Anesthesia
- ☐ Significant Medical History

Comments _____

- ☐ Treatment has been attempted
- ☐ Treatment has not been attempted

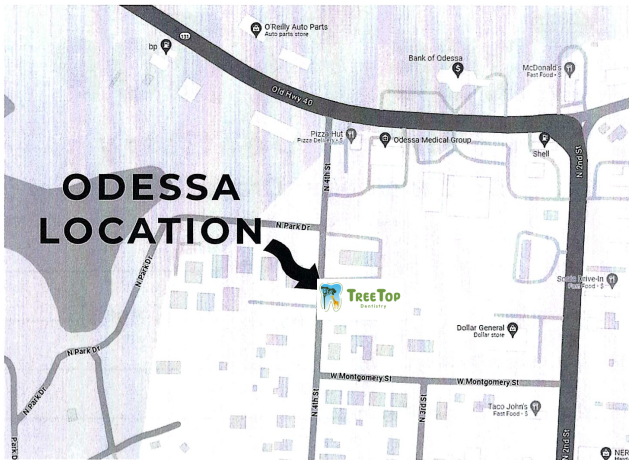
Radiographs:

- ☐ None Available
- ☐ X-rays sent to Office

In order to provide the best professional care, we schedule an initial examination prior to any treatment. At that appointment we will discuss pertinent medical history, assess the cooperative ability of the child, and review all recommended necessary dental treatment.

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	



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