6102 82nd St., 2
Lubbock, TX 79424
P: 806.792.2288
F: 806.792.2768
info@double-t-smiles.com

DENTAL REFERRAL FORM

Referral Date: _____

Patient Name: _____

Date of Birth: _____

Referral Specialty:

Orthodontics ☐ Pediatric Dentistry: ☐

Sedation Needs:

None ☐ Nitrous Oxide ☐ Moderate to Deep Sedation ☐

Please Evaluate the Following Teeth:

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

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

Radiographs Date: _____

Panoramic: ☐ Bitewings: ☐ Periapical: ☐ FMX: ☐

Notes:

_____

_____

Dental Home:

Establish with Double T Smiles ☐

Return Following Treatment ☐

Referring Dentist: _____