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Date _____

Introducing _____

Referring Dr. _____

This patient is being referred for evaluation of the following:

- Checkup and Cleaning
- Toothache - Tooth # _____
- Broken Tooth
- Decay/Cavity
- Crown/Cap
- Dental Implant - Tooth # _____
- Dentures
- Gum Disease
- Root canal treatment - Tooth # _____
- Teeth whitening
- Wisdom teeth pain
- Other: _____

Patient also presents with and requires additional care due to:

- Fear & anxiety of dentistry
- Mental Disability
- Physical Disability
- Other: _____

Comments: _____

