Dr. Nathifa Smith DDS
Diplomate- American Board of Pediatric Dentistry

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Referring Doctor:_____
Address:_____
_____
Patient Name:_____
Patient Age:_____
Parent Name:_____

Phone Number:_____
FAX:_____
Appointment Date:_____
Appointment Time:_____
Patient Phone:_____
Parent Phone:_____

CALL REFERRING DOCTOR BEFORE TREATMENT: YES ❑ / NO ❑

Referred for (check all that apply):

- ❑ Space Maintainers
- ❑ Oral Conscious Sedation
- ❑ High Anxiety
- ❑ Hospital Dentistry
- ❑ Restorative Procedures
- ❑ Rx Analgesic _____
- ❑ Pediatric Surgery (e.g., Frenectomy, Fiberotomies, Extractions)
- ❑ Other: _____

I am sending the following: ☐ by Email ☐with Patient

Xrays: ☐Bitewings ☐Pa's ☐Pano ☐Other:_____

TEETH TO BE TREATED:

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

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

VERIFY TEETH TO BE TREATED: _____

INSTRUCTIONS/ REMARKS: _____

Doctor Signature Date