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TOOTH CLUES
• THE DENTAL DETECTIVE FOR KIDS •

DATE _____ / _____ / _____

PATIENT NAME _____

PATIENT DATE OF BIRTH _____ / _____ / _____

REFERRED BY DR. _____

REFERRING DR. PHONE (_____) _____ — _____

○ Please contact me to discuss this patient's treatment.

DATE OF LAST VISIT _____ / _____ / _____

DENTAL TREATMENT ATTEMPTED/PROVIDED ○ Yes ○ No

If yes, what treatment? _____

RADIOGRAPHS

○ Given to the parent/guardian ○ Emailed to the office ○ Not taken

REASON FOR REFERRAL

○ Comprehensive Care
○ Consultation / Second Opinion
○ Frenectomy
○ Special Needs / Complex Medical History
○ Please Review Sedation Options
○ Dental Trauma

PLEASE INDICATE THE TOOTH/TEETH TO BE TREATED

QUAD 1									QUAD 2								
1	2	3	A	B	C	D	E	F	G	H	I	J	14	15	16		
4	5	6	7	8	9	10	11	12	13								
RIGHT																LEFT	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		
T	S	R	Q	P	O	N	M	L	K								
QUAD 4																QUAD 3	

ADDITIONAL COMMENTS _____

Thank you for your referral!