Smile Island Dental

PEDIATRIC DENTISTRY

KATHRINA CARRASCO, DDS
Board-Certified Pediatric Dentist

Date: _____

Patient Name: _____ Patient DOB:_____

Parent/Guardian Name: _____

Parent/Guardian Phone: _____

Referring Doctor/Office:_____

Referring Doctor's Phone & E-mail: _____

Additional Information: _____

_____

_____

_____

Reason for Referral:
(check all that apply)

__ 1st Dental Visit
__ Dental Pain
__ Needs Treatment
__ Sedation
__ Special Needs Patient
__ Other: _____
_____

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

Radiographs: __ Taken (please email to info@smileislanddental.com)
__ None available; please take

PLEASE FAX OR EMAIL THIS REFERRAL FORM TO OUR OFFICE

8700 Preston Rd, Ste 126
Plano, TX 75024

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info@smileislanddental.com