NEW PATIENT REFERRAL

KidsSmile PAEDIATRIC DENTAL

Patient Details

Name

Date of birth Gender ☐ Male ☐ Female

Address

Telephone Mobile

Parent/Guardian(s)

Clinical problems

☐ Early childhood caries ☐ Dental trauma ☐ Cleft condition

☐ Medically compromised ☐ Oral pathology ☐ Special needs patient

☐ Dental anomalies ☐ Anxious/phobic patient ☐ Enamel defects

Notes:

Behaviour ☐ Calm ☐ Cooperative ☐ Anxious ☐ Uncooperative

Radiographs ☐ PA/BW's Date ☐ OPG Date

Referring Practitioner

Name

Address

Telephone Email

Signature Date

Patient's Appointment

☐ Appointment made ☐ Patient to phone ☐ KidsSmile to phone patient

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