Kennebec River Dentistry

59 Davenport Streert
Augusta, Maine 04330
Tel # 207-621-1111
Fax # 207-621-1119
info@kennebecriverdentistry.com

Referral Form

Office Name: ____ is referring:

Patient Name:____ Patient DOB: ______________

Patient Phone Number: ___________________________________

TO: KENNEBEC RIVER DENTISTRY

Reason for Referral;

- ☐ Comprehensive Evaluation/Diagnostics
- ☐ TMJ/TMD Evaluation
- ☐ Orthodontic Evaluation
- ☐ Extraction
- ☐ Cosmetic Dentistry
- ☐ Sedation Dentistry
- ☐ Implant Diagnostics
- ☐ Root Canal

☐ Other:____

☐ Check if Evaluation is Comprehensive

Teeth to be Extracted/Evaluated/Treated:

A B C D E | F G H I J

Patient's Right 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 Patient's 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

Does the patient require pre-med? ☐ YES ☐ NO If yes, what kind? ________________

Any medical conditions requiring attention? ___________________________

____

Any Radiographs/Clinical notes being sent? ☐ YES ☐ NO

Radiographs dated:______________________ Clinical Notes dated:__________________

Referring Provider Name: ____

Provider's Signature: _____________________________________ Date: ___________

Referring office Telephone#: ___________________________________

Referring Office Address: ______________________________________

____