



WILSON DENTAL

728 E. Ridge Road
Rochester, NY 14621
(585) 491-7800 Fax (607) 238-1276

PEDIATRIC REFERRAL

Date: _____ Parent/Guardian name and contact number : _____

Introducing: _____ DOB: _____ Insurance: _____

Patient has been referred for the following:

- ___ Consultation
- ___ Consultation and Care
- ___ Treatment under general anesthesia
- ___ Rampant caries
- ___ Behavior/age
- ___ Special needs

Areas of Concern:

Permanent Dentition

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

Primary Dentition

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

Remarks: _____

Referred By: _____

Signature: _____

Date: _____ Phone Number: _____