Smyles & Co.
Family Dentistry

Referral of Children & Adults with Additional Needs

Date: _____

Patient's Name: _____

Patient's Phone: _____ Date of Birth _____

Patient's Email Address: _____

Referred By: _____

Office Name/ Address: _____

Office Phone: _____

PLEASE EVALUATE FOR:

- [ ] Full Mouth Evaluation & Treatment
- [ ] Treatment Only of Specified Teeth (please list teeth in comment section)

Comments: _____

★ REASON FOR REFERRAL

- [ ] Behavior Guidance
- [ ] Age
- [ ] Medical Conditions/Special Needs
- [ ] Sedation Consultation

Other: _____

We accept most dental plans-hablamos espanol
Thank you for your referral.

In most cases, the first appointment will be for a consultation only.
Please consult our office directly in regards to your first appointment.

3827 E Main Street
Saint Charles, Illinois 60174
630-524-4445
630-524-4446
www.smylesandcompany.com
info@smylesandcompany.com

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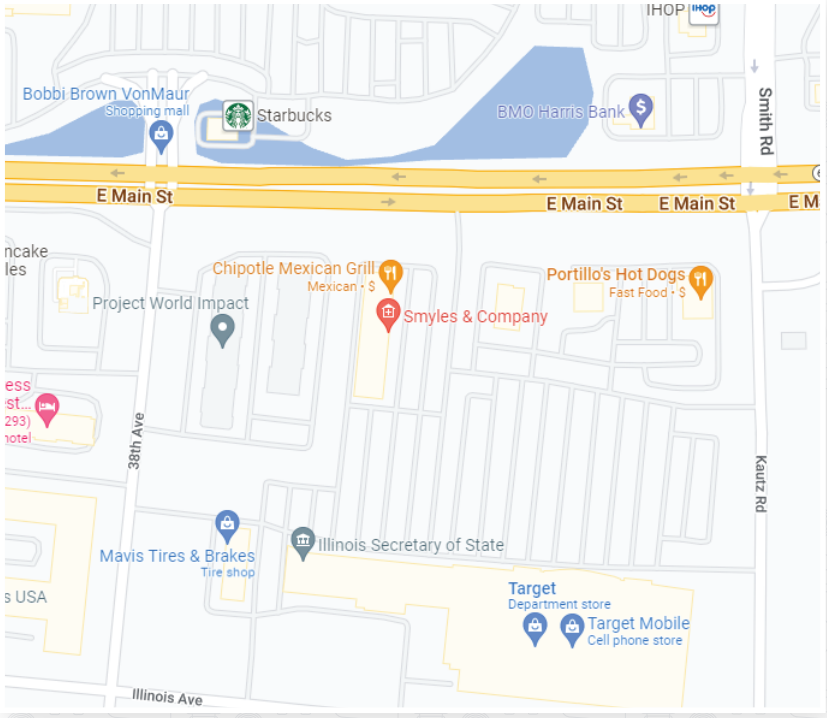
Family Dentistry



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