Dr. Clint Rau, D.D.S. - Pediatric Dentist
605 Reed Ave.
Manitowoc, WI 54220
920-652-1100 - Fax 920-652-1200

Email X-rays to: office@youngsmileswi.com
****INCLUDE ALL CLINICAL NOTES****

Patient Referral

Patient's Name ______________________________ Date of Birth ____________________

Names of Parents or Guardians ______________________________ Phone #s ____________________

______________________________ ____________________

Address ____

Insurance ____

Reason for Referral (CIRCLE ANY OF THE FOLLOWING): High Caries Rate Abscess Pain Dental Injury

Other: ____

Significant Medical History: ____

____

Significant Social History: ____

For Referring Dental Offices: ****PLEASE INCLUDE ALL PAST CLINICAL NOTES FROM PREVIOUS VISITS****

X-rays:

________ Have Been Sent Date X-rays Were Taken: ____________________

________ Young Smiles Will Need To Take

Date of Last Panorex File: __________________

Comments:

Signature of Referring Doctor ______________________________ **Date** ____________________

Printed Name of Referring Provider ______________________________ **Date Referred** ________________

Name of Dental Office ____

****BE SURE TO INCLUDE ALL PREVIOUS CLINICAL NOTES FROM ALL PREVIOUS VISITS****