maineemergencydentist

P: 207-910-2646 F: 207-602-6044 www.maineemergencydental.com my911dentist@gmail.com

Referring Provider Information

- **Referring Provider:** _____
- **Phone:** _____
- **Date of Referral:** ____ / ____ / _____

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone Number:** _____

Reason for Emergency Referral

☐ **Severe dental pain** ☐ **Facial swelling**
☐ **Dental trauma / injury** ☐ **Possible abscess**
☐ **Broken tooth** ☐ **Other (please specify):** _____

Tooth/Area Involved

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

Treatment Plan (i.e., fillings, extractions, denture. Please include surfaces and attach treatment plan if available)

Tooth # **Suggested Treatment**

_____
_____
_____
_____
_____
_____

Urgency Level

☐ **Immediate** – Same day/next day ☐ **Urgent** – Within 24 hours ☐ **Non-urgent** – As soon as available

Radiographs / Records Provided

☐ Sent via email ☐ Printed copy given to patient ☐ Not available

Additional Information/Medical Alerts Pertaining to Patient

_____
_____
_____
_____
_____
_____

Provider Name: _____ **Office name:** _____

Signature: _____ Date: ____ / ____ /_____