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Clinton, MS 39056
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S. Lee Grubbs, D.M.D.

Patient: ______________________________

Reason for referral: ❑ Consultation ❑ Treatment
❑ Other (see below)

Please Mark Tooth For Treatment

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

Referring Doctor: ______________________________

Date: ______________________________

Appointment Date/Time: ______________________________

Other Instructions: ______________________________

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Prescriptions Given: ______________________________

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PLEASE NOTIFY OUR OFFICE 24 HOURS IN ADVANCE IF UNABLE TO KEEP YOUR APPOINTMENT.