Children's DENTISTRY

Date _____

Patient Name _____ Age _____

Parent Name _____

Phone Number _____

Referring Doctor Name and Clinic _____

Reason for Referral ☐ Decay ☐ Conscious Sedation
☐ Special Needs ☐ General Anesthesia

Radiographs ☐ None available ☐ Emailed

Comments _____

_____

Please evaluate the following teeth (please circle)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
RIGHT				A	B	C	D	E	F	G	H	I	J			LEFT
				T	S	R	Q	P	O	N	M	L	K			
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

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