



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	
R			A	B	C	D	E	F	G	H	I	J			L	
I															E	
G															F	
H			T	S	R	Q	P	O	N	M	L	K			T	
T																
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

650 N. MILLER ST. WENATCHEE, WA 98801

509-662-3621

WWW.SMILEBUGG.COM | INFO@SMILEBUGG.COM