



smileland

PEDIATRIC DENTISTRY & BRACES

Date _____

Patient Name _____ Age _____

Referring Doctor _____

Referring Doctor Tel. No. _____

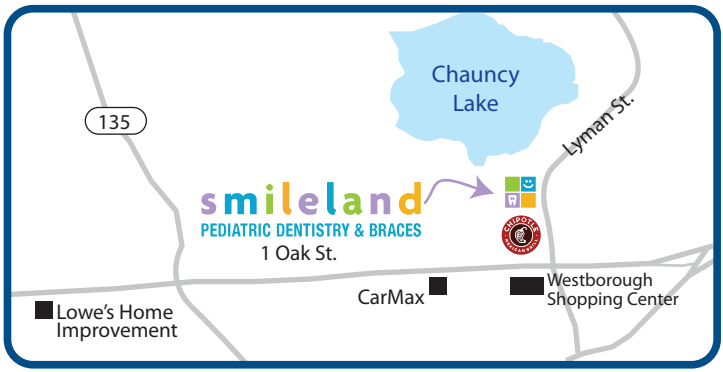
Reason for Referral 1st Dental Visit Toothache Decay
 Special needs Orthodontics Invisalign Sedation

Radiographs None available X-rays sent with patient

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



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