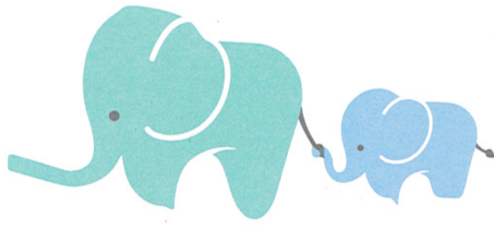


GROWING SMILE

PEDIATRIC DENTISTRY AND BRACES

Date ____________

Patient Name ________________________________ Age ______

Referring Doctor ________________________________

Referring Doctor Tel. No. ________________________________

Reason for Referral ❑ 1st Dental Visit ❑ Toothache ❑ Decay

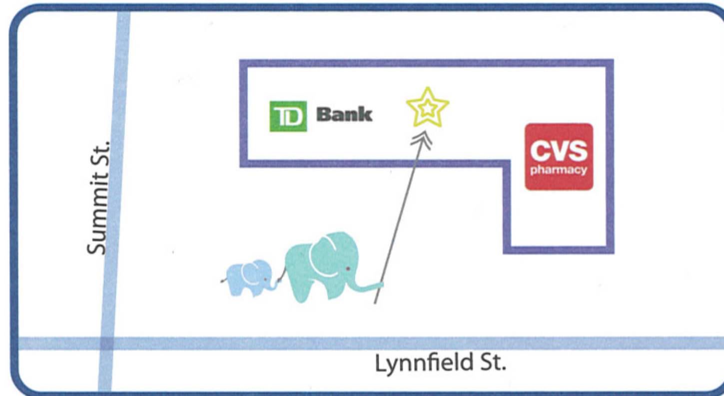
❑ Special needs ❑ Orthodontics ❑ Invisalign ❑ Sedation

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	
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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