

Name: _____ Age: _____ Date: _____

Referring Office: _____ Phone #: _____

PLEASE EVALUATE THE FOLLOWING TEETH (CIRCLE PLEASE)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			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

REASONS FOR REFERRAL:

- | | | |
|--|--|---------------------------------|
| ☐ Comprehensive Care | ☐ Special Needs | ☐ Trauma |
| ☐ Sedation/Anesthesia | ☐ Caries/Decay | ☐ Other |

RADIOGRAPHS: ☐ X-rays w/ Pt ☐ X-rays emailed ☐ None

PLEASE CONTACT PRIOR TO TREATMENT: ☐ Yes ☐ No

COMMENTS
