pediatric smiles OF CYPRESS

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A Gentle Experience

Referred By:_____ Date:_____

Introducing: _____ DOB:_____

Patient Contact: Home:_____ Cell: _____

Radiographs:

☐ None available ☐ Emailed to: info@pediatricsmilesofcypress.com
☐ Sent with patient

PLEASE EVALUATE FOR:

☐ 1st Dental Visit ☐ Toothache ☐ Decay ☐ Extraction
☐ Special Needs ☐ Trauma ☐ Sedation / Anesthesia
☐ Other: _____

Please evaluate the following teeth (please circle)

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			
R															L
			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

Comments: _____

_____

PLEASE SEND THIS REFERRAL WITH THE PATIENT OR FAX IT TO OUR OFFICE

Thank you for allowing us to assist your patients with their smiles!