Springfield Kids Dentist

Dentistry For Kids

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Referring Office/ Doctor ______________________ Date ________

Patient _______________________________ DOB ____________

Recent X-rays (if any) __________________________________

Reason for referral :

☐ 1st Dental visit ☐ Toothache ☐ Special Needs

☐ Nitrous Oxide ☐ Sedation/General Anesthesia

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	

Comments : ____

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www.springfieldkidsdentistry.com