JOYOUS SMILES™

PEDIATRIC DENTISTRY

Date:__________________

Patient Name:____ Age:__________

Referring Doctor:____

Referring Doctor Tel. #:____

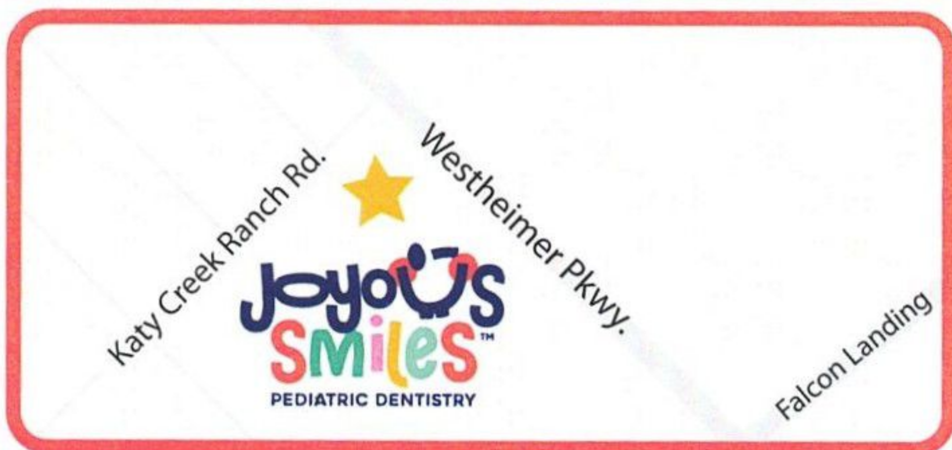
Reason for Referral: ❑ 1st Dental Visit ❑ Toothache ❑ Decay ❑ Extractions
❑ Special Needs ❑ Trauma ❑ Sedation/Anesthesia ❑ Space Maintainer

Radiographs: ❑ None Available ❑ X-rays sent with patient

Comments:____

Please evaluate the following teeth (please circle)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
				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	



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