

DATE

PATIENT NAME

PATIENT AGE

REFERRING DOCTOR

REFERRING DOCTOR PHONE NUMBER

REASON FOR REFERRAL

- 1<sup>st</sup> dental visit     toothache     decaylip tie   
 special needs     trauma     sedation/anesthesia  
 tongue tie     airway assessment     myofunctional therapy

RADIOGRAPHS

- x-rays sent with patient     none available

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					
				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	
																		LEFT

COMMENTS