



PEDIATRIC DENTISTRY OF LOVELAND

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Date: _____

Introducing: _____

Patient

Date of Birth: _____ Age: _____

Parent's Name: _____

Phone: _____

Referred by Dr.: _____

Prophy & fluoride treatment Completed? Yes No Date: _____

X-Rays enclosed? Yes No

Reason for Referral: Consultation Treatment Possible Sedation Dentistry

Teeth for Evaluation:	Right	1	2	3	A	B	C	D	E	F	G	H	I	J	Left	<input type="checkbox"/> Please evaluate all teeth			
		32	31	30	29	28	27	26	25	24	23	22	21	20			19	18	17
					T	S	R	Q	P	O	N	M	L	K					

Behavior at prior appointments: _____

Comments: _____

Please call me before proceeding with treatment?

Yes No

Phone: _____

Follow-up -- Is patient to be followed for recalls by Pediatric Dentistry of Loveland?

Yes No