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 4	B 5	C 6	D 7	E 8	F 9	G 10	H 11	I 12	J 13	14	15	16	Left
	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	

☐ **Please evaluate all teeth**

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**