South Coast Pediatric Dentistry™

Dr. Kent N. Do
Pediatric Dentist

Thank you for your referral!

Introducing:_____ Date:_____

Please evaluate the following: DOB:_____

- ☐ Tooth Ache
- ☐ Operative needed
- ☐ Trauma - teeth / alveolus / soft tissue
- ☐ Caries
- ☐ Abcess involvement / symptomatic
- ☐ Sedation / anesthesia
- ☐ Special needs patient
- ☐ Difficult behavior

Significant Medical History: ☐ Yes ☐ No

Further Remarks:

upper

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

left *lower* *right*

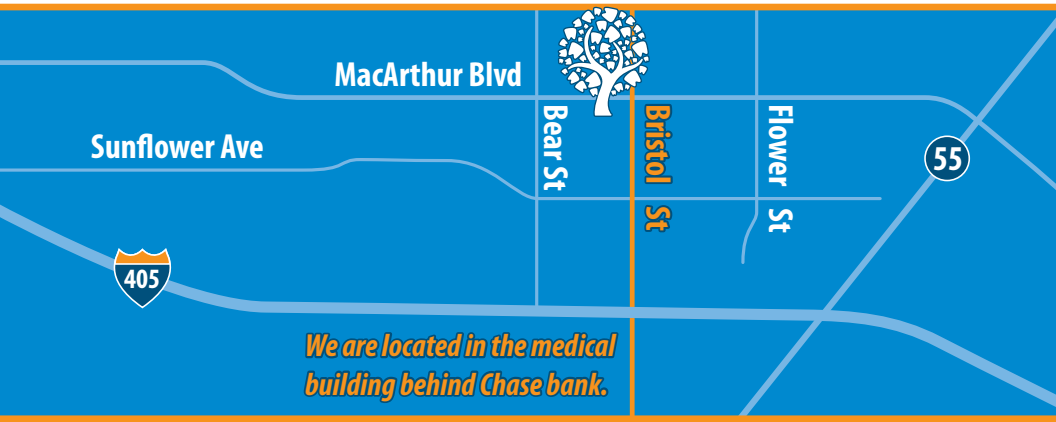
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

X-rays ☐ mailed ☐ emailed to DrKent@SoCoSmiles.com ☐ none

Referred by Dr._____ Phone _____

Growing Healthy Smiles in Orange County

South Coast
Pediatric Dentistry



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