KAO PEDIATRIC DENTISTRY

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Introducing: _____ D.O.B. _____

Parent/Guardian: _____ Tel. #_____

Referring Doctor: _____Tel. #_____

Reason for Referral: ☐ 1st Dental Visit ☐ Toothache ☐ Caries ☐ Trauma

Comments_____

_____

Please email radiographs to drkaokidsdentist@gmail.com

Please evaluate the following teeth (please circle)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
Right			T	S	R	Q	P	O	N	M	L	K			Left
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Signature_____ Date _____