The Children's Dental SPECIALIST

"WHERE THE SEEDS OF GOOD ORAL HEALTH ARE PLANTED"

Introducing Patient_____Age_____

Reason for Referral:

__Extensive Decay
__Space Maintenance
__Fractured Tooth
__Pulp Therapy
__Panoramic X-ray
__Sedation
__Patient Management
__Fissure Sealant
__Malocclusion/Oral Habits
__Medical History/Special Needs
__Other (Specify Below)

RIGHT	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		LEFT
					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

Remarks_____

_____

_____

_____

_____

Referred by Dr._____

Phone_____ Date _____

☐ **The Children's Dental Specialist Southbay**
20930 Bonita Street
Suite Y
Carson, CA 90746
PH 310-327-7969
FAX 310-327-7981

☐ **The Children's Dental Specialist Ladera**
5035 W. Slauson Avenue
Suite G
Los Angeles, CA 90056
PH 323-296-0211
FAX 323-296-0213