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(423) 362-5437 or (423) 362-KIDS

Patient Name: ____

Referred By: ____________________________ Referral Date: __________

Reason for referral & teeth needing treatment or comments: ______________

____

____

A B C D E F G H I J

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

T S R Q P O N M L K

The following treatment has already been performed:

______ Panoramic Xray date: ____________

______ Additional Radiographs type:____________ date: ____________

Was in office treatment attempted? Y / N date: ____________