Seastar
pediatric dentistry

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date

patient name

patient age

referring doctor

referring doctor phone number

reason for referral

- ☐ 1st dental visit
- ☐ toothache
- ☐ decay
- ☐ special needs
- ☐ trauma
- ☐ sedation/anesthesia

radiographs ☐ x-rays sent with patient ☐ none available

evaluate the following teeth (please circle)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
right				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	

comments

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