



LITTLE SMILES DENTAL

DENTISTRY FOR KIDS

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Referring Doctor _____ Date _____

Patient _____ DOB _____

Recent X-rays (if any) _____

Reason for referral :

- 1st Dental visit Toothache Special Needs
- Nitrous Oxide Sedation/General Anesthesia

Please evaluate the following teeth (please circle)

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

Comments : _____

