treehouse

PEDIATRIC DENTISTRY

Sana Yousaf, DDS

Board Certified Pediatric Dentist

Date: _____

Patient Name: _____ Age: _____

Guardian Tel. #: _____

Referring Doctor: _____

Referring Doctor Tel. #: _____

Reason for Referral:

❑ First Visit ❑ Pain ❑ Cavities ❑ Extraction(s) ❑ Trauma
❑ IV Sedation/ General Anesthesia
❑ Other _____

Radiographs: ❑ None Available ❑ X-rays taken
Please forward X-rays to: hello@treehousekidsdentist.com

Services Already Provided?

❑ Exam ❑ Prophylaxis ❑ Fluoride ❑ I'm not sure

Comments: _____

Please 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	

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