HELLO SMILES
PEDIATRIC DENTISTRY

Date _____

Patient's Name _____ DOB:_____

Referring Doctor _____

Referring Doctor's Phone # _____

Reason for Referral:

- ◯ 1st Dental Visit
- ◯ Toothache
- ◯ Decay
- ◯ Special needs
- ◯ Trauma
- ◯ Sedation/Anesthesia
- ◯ Other _____

X-Rays:

- ◯ None Available
- ◯ Sent w/ Patient
- ◯ E-mailed to info@hellosmileskids.com

Notes: _____

_____

_____

Please evaluate the following teeth (please circle)

	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			
RIGHT																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

Ansony Kim, DDS BOARD CERTIFIED PEDIATRIC DENTIST

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