# HELLO SMILES
## PEDIATRIC DENTISTRY

Date _____

Patient's Name _____ DOB: _____

Parent's Name _____ Phone: _____

Dental Insurance Company _____

Referring Doctor _____

Reason for Referral:

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

X-Rays:

- ◯ None Available
- ◯ Sent w/Patient
- ◯ Emailed 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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