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Libertyville Pediatric Dentistry

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Evaluate the following teeth (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

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

Patient Name: _____ Referred by: _____

Age: _____ DOB: _____ Phone: _____ X-Rays: ☐ Sent by Dr. ☐ None

Request: ☐ Trauma ☐ Caries ☐ Well Baby Check ☐ Ortho Eval

Other: _____