JUST KIDS

PEDIATRIC DENTISTRY
& ORTHODONTICS

TREATMENT REFERRAL

Date: _____

Patient name: _____ Age: _____

- ❑ Complete examination
- ❑ Cleaning and fluoride application
- ❑ Oral hygiene is not adequate. Please emphasize good home care at your next appointment
- ❑ Restoration(s): _____
- ❑ Please extract: _____

			A	B	C	D	E	F	G	H	I	J				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			

Comments: _____

_____

_____

Referred by: _____

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