Pediatric Dentistry and Orthodontics of Jackson

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PEDIATRIC DENTISTRY
AND ORTHODONTICS OF JACKSON

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Patient Name:_____ D.O.B:_____

Referring Provider:_____

Referring Provider Tel. #:_____

Reason for Referral:

❑ **Pediatrics:**

❑ Toothache ❑ Decay ❑ Special Needs
❑ Trauma ❑ Oral/Conscious Sedation

❑ **Orthodontics:**

❑ Crowding ❑ Spacing ❑ Molar Uprighting ❑ Overbite ❑ TMJ
❑ Impacted Tooth ❑ Overjet ❑ Space Maintenance ❑ Cross Bite
❑ Other_____

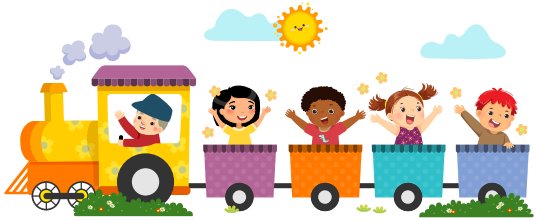
Radiographs: ❑ None Available ❑ X-rays Sent With Patient

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	

Doctor's Signature Date



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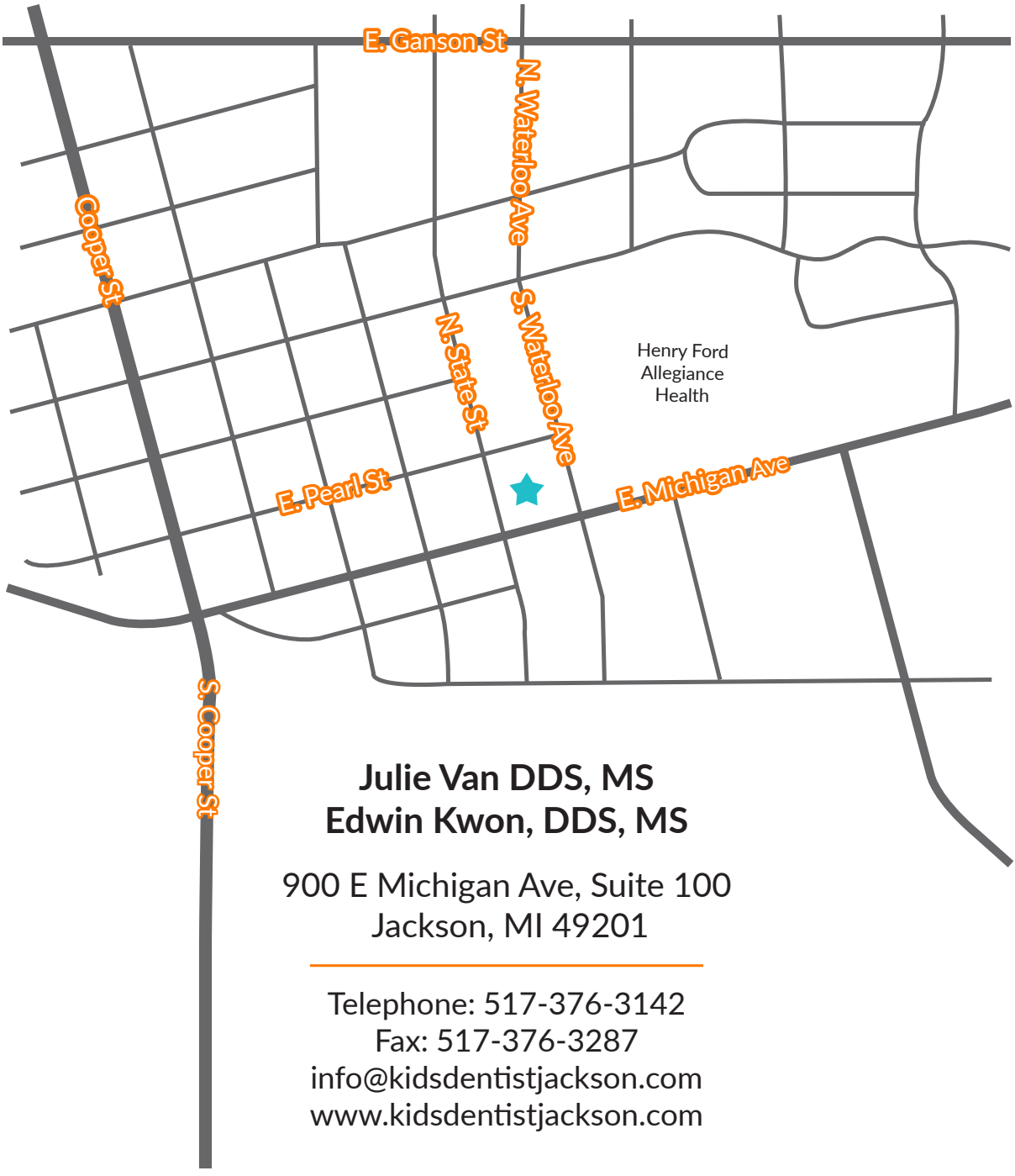

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