PHAMILY Pediatric Dentistry

Hung Pham DDS, MS

Patient Name: _____ **Age:**_____

Referring Doctor: _____

Referring Doctor Telephone Number: _____

Reason for Referrral : ☐ **1st Dental Visit** ☐ **Toothache** ☐ **Decay**

☐ **Trauma** ☐ **Other**

Radiographs: ☐ **None taken** ☐ **X-rays sent with patient**

Comments: _____

_____

Please circle teeth needed for treatment:

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

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