hampton roads pediatric dentistry

hrpediatricdentistry.com

Dr. Bobby Garofalis & Associates

To Doctor: _____ Patient: _____

Phone: _____ D.O.B.: _____

In order to continue this patient's treatment, we would appreciate if you would please perform the procedure(s) indicated below. Circled teeth require treatment and an X indicates extraction.

- ◯ *Full Mouth X-Rays*
- ◯ *Fluoridation*
- ◯ *Examination & Restoration of Any Caries Found*
- ◯ *Bite Wings*
- ◯ *Cleaning*
- ◯ *Other X-Rays*
- ◯ *Please Stress Oral Hygiene*
- ◯ *Extraction/Wisdom Teeth*

Tooth Chart

				a	b	c	d	e	f	g	h	i	j				
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	**L**
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				

Remarks: _____

_____

_____

_____

Patient's X-Rays are enclosed for your review.

We appreciate your prompt attention in the request for treatment of this patient. If you have any questions, please give us a call. Thank you!

Referring Doctor: _____ Date: _____

Address: _____ Phone: _____