PEDIATRIC DENTISTRY OF CENTRAL OHIO

Joshua M. Leavitt, D.M.D., M.S.

Date: _____

Referring Dr. _____

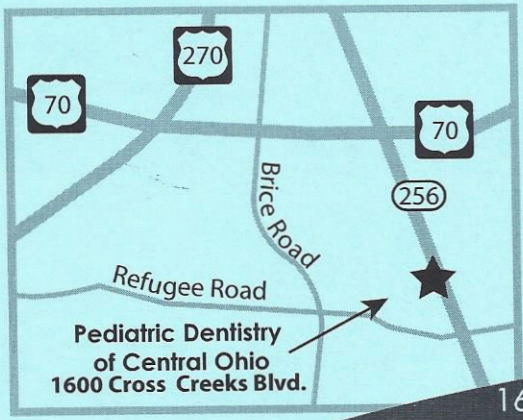
Phone: _____

Introducing my patient _____

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	

Special Instructions or remarks: _____



Radiographs:

- ❑ None available
- ❑ X-rays sent with patient
- ❑ Emailed

PDCO1600@gmail.com

X-Rays Taken _____

Prophy Date _____

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