FORT COLLINS
LONGMONT
LOVELAND

Patient Name: ______________________________ D.O.B: ________________

Referring Office: ____

Referring Doctor: ____

Referring Office Tel No: ____

Reason for Referral: Toothache Decay Special needs

Trauma Sedation/Anesthesia

Radiographs: None available X-rays sent with patient

Comments: ____

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Please evaluate the following teeth (please circle)

1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
A B C D E	F G H I J
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 ________________

Fax: (970) 225-1574 Info@toothzone.com www.toothzone.com