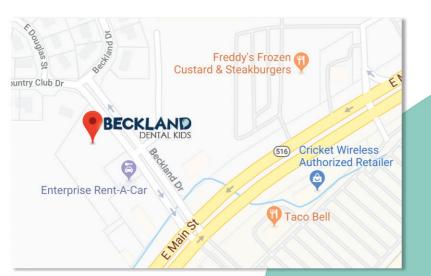


AND THE RESERVE		
Date		

Patient Name		Age						
Guardian Name								
Phone #	In	surance Info						
Patient Referred for:								
Full Mouth Eval & Treat	ment	Special Needs						
☐ Dental Pain		Extractions						
☐ Treatment Only of Spec	ified Teeth	Decay/Dental Caries						
Other		Sedation						
Radiographs								
None available	Emailed	Sent with Patient						
Referring Doctor								
Comments								

Please evaluate the following teeth (please circle)															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
F	2		Α	В	С	D	Ε	F	G	Н	I	J			L
F	! !		Т	S	R	Q	Р	0	N	M	L	K			F T
3	2 31	30	29	28	27	26	25	24	23	22	21	20	19	18	17



P: 505.278.8806 F. 505.278.8807

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