GREAT SMILES

PEDIATRIC DENTISTRY & ORTHODONTICS

www.GreatSmiles.org

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Introducing _____ DOB _____

Patient Phone _____

Referred By _____ Date _____

For: Limited Dental Exam Evaluate/treat any decayed area

Complete/Limited Orthodontic Evaluation

Xrays: Mailed Emailed With Patient Take PRN

	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Left
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

	E	D	C	B	A	A	B	C	D	E	
Right	A	B	C	D	E	F	G	H	I	J	Left
	T	S	R	Q	P	O	N	M	L	K	
	E	D	C	B	A	A	B	C	D	E	

Remarks or Special Instructions _____

TOP: PATIENT COPY BOTTOM: DOCTOR COPY

SOLANA BEACH
N
I-5
GREAT SMILES
PEDIATRIC DENTISTRY & ORTHODONTICS
LOMAS SANTA FE DRIVE
NARDO
STEVENS

CARLSBAD
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PALOMAR AIRPORT RD.
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HIDDEN VALLEY RD.
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AVIARA PKWY