

Pediatric Dentistry

— OF ROUND ROCK —

SAGE THAMES, DDS

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Referred By: _____

Introducing: _____ DOB: _____

Patient Contact Home: _____ Cell: _____

PLEASE EVALUATE FOR:

- | | |
|--|---|
| ☐ Comprehensive Care | ☐ Extensive Decay |
| ☐ Limited Care | ☐ Anxiety |
| ☐ Sedation / General Anesthesia | ☐ Special Healthcare Needs |
| ☐ Other: _____ | |

X-RAYS: ☐ Given To Patient ☐ Emailed ☐ Mailed ☐ Please Take

DENTAL RESTORATIONS: ☐ **Have** Been Attempted ☐ Have **Not** Been Attempted

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT	
	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		

NOTES / REQUESTS:

THANK YOU FOR YOUR REFERRAL!

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