SIERRA DENTAL

FAMILY DENTISTRY . ORTHODONTICS . PERIODONTICS

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INTRODUCTION

PATIENT NAME: _____

AGE: _____ HOME PHONE NUMBER: (_____) _____ - _____

CELL PHONE NUMBER: (_____) _____ - _____

PARENT / GUARDIAN NAME: _____

PATIENT'S COMPLAINT

_____

_____

_____

COMMENTS

_____

_____

_____

X-RAYS AVAILABLE ❍ Y ❍ N DATE TAKEN:_____

CARIES

❍ NONE ❍ UNDER TREATMENT ❍ TREATMENT REQUIRED

OTHER TREATMENT PLANNED

❍ NO ❍ YES

_____

_____