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INTRODUCING _____ DATE: _____
CONTACT PHONE NUMBER: _____ D.O.B: _____
REFERRED BY _____ OFFICE NUMBER: _____

EXAMINE FOR:

- EXAMINE FOR DENTAL CARIES EXAMINE FOR ORTHODONTIC PROBLEMS
- TREAT TRAUMATIZED TOOTH _____
- TREAT TOOTHACHE
- PAIN: AT NIGHT EATING SPONTANEOUS
- OTHER _____
-

RADIOGRAPHS:

- X-RAY EMAILED TO INFO@SDDENTALSPECIALISTS.COM X-RAYS SENT WITH PATIENT
- PLEASE TAKE X-RAYS
- OTHER

COMMENTS: _____
