iSmile Dental, Inc.
iSmile Implant & Orthodontic Center
www.i-smiledental.com

Patient Name:_____

Patient Phone Number:_____

Referred by:_____ Date:_____

Tooth to Be Evaluated:

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

Request/Comments:

Radiographs:
☐Please Take ☐Will Accompany Patient ☐Have Been Sent

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