lakeside

PEDIATRIC DENTISTRY

RYAN J HUGHES DDS MS

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(503) 635-3483

lakesidepediatricdentistry.com

Date: _____ Patient Name: _____

DOB: _____ Contact (Parent/Guardian): _____

Phone Number/Email: _____

Referring Doctor: _____

RADIOGRAPHS

❑ Emailed to office@lakesidepediatricdentistry.com ❑ Please Take ❑ Sent with Patient

PLEASE CIRCLE TEETH TO TREAT

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

REMARKS/BRIEF TREATMENT PLAN (CONFIRM TOOTH #'S) _____

❑ Return to Referring Office ❑ Stay at Lakeside for Continued Care

Email: office@lakesidepediatricdentistry.com lakesidepediatricdentistry.com

Fax: 503-699-0345

White – Patient Copy **Yellow –** Chart Copy