Soo Jun, DMD
Board Certified Pediatric Dentist

FEDERAL WAY
PEDIATRIC DENTISTRY

Patient Name _____ Date _____

Referred by Dr. _____

- ☐ Routine Preventive Care
- ☐ Restorative Care (with sedation/general anesthesia)
- ☐ Specialist Consultation & Diagnosis re:

_____

_____

- ☐ I would like to be contacted to discuss
- ☐ I would like this patient to return to my office for recall visits
- ☐ Please continue to see this patient for future recall visits

Radiographs:

- Full mouth series available ☐ Dated _____
- Bitewing type available ☐ Dated _____
- Panoramic xray available ☐ Dated _____

- ☐ **Emailed to the office at office@FederalWayPediatricDentistry.com (preferred method)**
- ☐ Mailed to the office on _____
- ☐ Parents will hand carry to the office

## AFFECTED TEETH

| | | | 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 | | | |

FEDERAL WAY PEDIATRIC DENTISTRY
1035 S 320TH ST. SUITE B • FEDERAL WAY, WA 98003 • 253-262-6589
www.FederalWayPediatricDentistry.com
office@FederalWayPediatricDentistry.com