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Referring Healthcare Provider: _____

Introducing: _____DOB: _____

Please provide evaluation for:

- ☐ Tongue-tie/Lip-tie
- ☐ Comprehensive treatment
- ☐ Caries
- ☐ Other
- ☐ Extractions
- ☐ Filling(s)
- ☐ Habit (thumb/finger/pacifier)
- ☐ Advanced behavior management

Remarks: _____

_____

_____

Radiographs taken? ☐ Yes ☐ No

If yes, please specify attached or sent via mail/email/fax: _____

Please circle teeth for evaluation (if applies):