141 Ma'a St.
Kahului, HI

808-419-7841

808-419-7842

justkeiki@gmail.com

Please provide a dental evaluation for:

Patient's Name: ______________________________ Age: ____________

Parent's Name: ______________________________ Phone Number: ____________

☐ Infant Dental Care	☐ Dental Infection
☐ Dental Decay	☐ Dental Trauma
☐ Nitrous Oxide	☐ Thumb/ Finger Habit
☐ Sedation/ Hospital Dentistry	☐ Other

Date of last visit with your office:

X-Rays taken: ______________________________ Date: ____________

☐ Attached ☐ Emailed

Referred by Dr. ______________________________ Dr.'s Phone ____________

Practice Name: ______________________________

(A parent or legal guardian must accompany the patient)

			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	32	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: ______________________________

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Email or fax completed form to Just Keiki Pediatric Dentistry