Dr Surillo's
CHILDREN'S
BRACES AND DENTISTRY INC.

Dr. Santiago Surillo, DDS, MS
and Associates

Patient's Full Name: _____ Date: _____

Referring Doctor: _____ Phone: _____

Remarks: _____

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

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

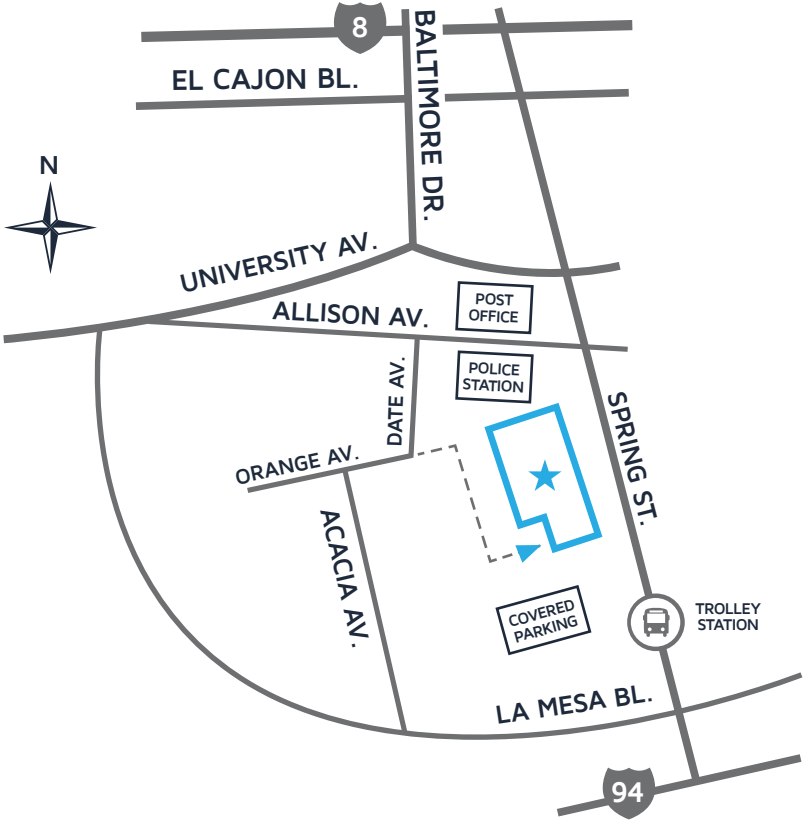
Pediatric Dentistry

- ☐ Evaluate all Dentition/Possible Dental Caries
- ☐ Dental Abscess/Infection Present
- ☐ Child-patient is Uncooperative for Treatment
- ☐ Oral-Hygene Management
- ☐ Digit/Pacifier Habits
- ☐ Nursing/Bottle Decay
- ☐ Extract and/or Treat Marked Teeth

Orthodontics

- ☐ Evaluate for Orthodontic Treatment
- ☐ Evaluate for Orthodontic/Orthognathic Treatment
- ☐ Evaluate Impacted Teeth: _____
- ☐ Evaluate Dento-facial Growth
- ☐ Dental-Arch Space Management
- ☐ Dento-Facial Asymmetry Noted
- ☐ Other: _____

Doctor's
Signature: _____



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4700 Spring Street, Suite 104
La Mesa, CA 91942

(619) 461-6166
cbdstaff@sandiegokidsdentist.com
www.sandiegokidsdentist.com

Appointment Date: _____

Appointment Time: _____

Special Instructions: _____