



# TOOTH CLUES

THE DENTAL DETECTIVE FOR KIDS

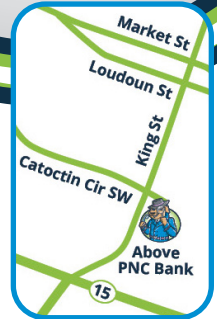
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DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT NAME \_\_\_\_\_

PATIENT DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

REFERRED BY DR. \_\_\_\_\_

REFERRING DR. PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please contact me to discuss this patient's treatment.

DATE OF LAST VISIT \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DENTAL TREATMENT ATTEMPTED/PROVIDED  Yes  No

If yes, what treatment? \_\_\_\_\_

### RADIOGRAPHS

Given to the parent/guardian  Emailed to the office  Not taken

### REASON FOR REFERRAL

- Comprehensive Care
- Consultation / Second Opinion
- Frenectomy
- Special Needs / Complex Medical History
- Please Review Sedation Options
- Dental Trauma

PLEASE INDICATE THE TOOTH/TEETH TO BE TREATED

QUAD 1										QUAD 2															
1	2	3	A	B	C	D	E	F	G	H	I	J	15	16											
RIGHT																LEFT									
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17										
QUAD 4										QUAD 3															
								T	S	R	Q	P	O	N	M	L	K								

ADDITIONAL COMMENTS \_\_\_\_\_

*Thank you for your referral!*