

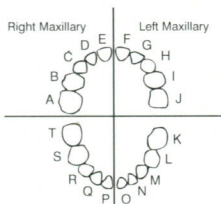


# ALLGRINS4KIDS

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Deciduous teeth



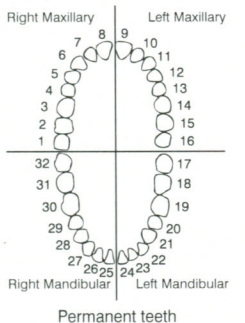
**Patient Name:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_  
 \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Permanent teeth

**Behavior:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Radiographs:** \_\_\_ Y / N \_\_\_ Given to Patient/ Mailed/ E-mailed \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_

**Date:** \_\_\_\_\_