HAASDENTAL ASSOCIATES

Patient: _____

DOB: _____ Phone: _____

Patient Address: _____

Date: _____ Referring Doctor: _____

☐ Comprehensive Exam ☐ Emergency Exam ☐ Sedation Dentistry

☐ Special Needs Patient ☐ Early Childhood Caries ☐ Anxiety/ Behavior Management

☐ Orthodontic Evaluation ☐ Other: _____

☐ Treatment has been attempted ☐ Treatment has not been attempted

Radiographs: ☐ None are available ☐ Emailed/sent to office

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

4 Manchester Ave
Derry, NH 03038
P: 603-434-1586
pedo@haasdentalnh.com

51 Webb Place Suite 150
Dover, NH 03082
P: 603-617-2882
pedo.dover@haasdentalnh.com

4 Coliseum Ave Unit E-3
Nashua, NH 03063
P: 603-546-7373
pedo.nashua@haasdentalnh.com