

DR. CONSTANCE SCHRECK
DR. MICHAEL BOGRAN

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Pediatric Dental Care
OF YUKON

PATIENT NAME _____ DOB _____

PARENT NAME _____

PHONE NUMBER _____ May we contact this patient
to schedule? ☐ Yes ☐ No

REFERRED BY DR _____

REASON FOR REFERRAL

- ☐ First Dental Visit ☐ Decay ☐ Trauma
☐ Toothache ☐ Special Needs ☐ Sedation
☐ Other/Comments _____

PLEASE EMAIL RADIOGRAPHS TO: office@pdcyukon.com

PLEASE CIRCLE TEETH TO BE EVALUATED

PERMANENT

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

PRIMARY

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



Pediatric Dental Care of Yukon
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