BIG APPLE PEDIATRIC DENTISTRY

Henry Martinez DMD, MBS
Diplomate, American Board of Pediatric Dentistry
Fellow, American Academy of Pediatric Dentistry

Date_____

Patient Name _____ Age _____

Referring Doctor _____ Ref. Doctor Tel. No. _____

Reason for Referral:

❑ 1st Dental Visit ❑ Toothache ❑ Decay

❑ Special Needs ❑ Trauma ❑ Sedation/Anesthesia

Radiographs: ❑ None available ❑ X-rays taken

Please forward xrays to: office@bigapplepediatricdentistry.com

Comments_____

_____

Please evaluate the following teeth (please circle)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT				A	B	C	D	E	F	G	H	I	J				LEFT
				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	

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