Greenhaven pediatric dentistry

Brenda Ho, DDS
Board Certified Pediatric Dentist

Date _____

Patient Name _____ DOB: _____

Referring Doctor _____ Ref. Doctor Tel. No. _____

Parent Name _____ Parent Tel No. _____

Reason for Referral ❑ 1st Dental Visit ❑ Toothache ❑ Decay

❑ Special needs ❑ Trauma ❑ Anesthesia

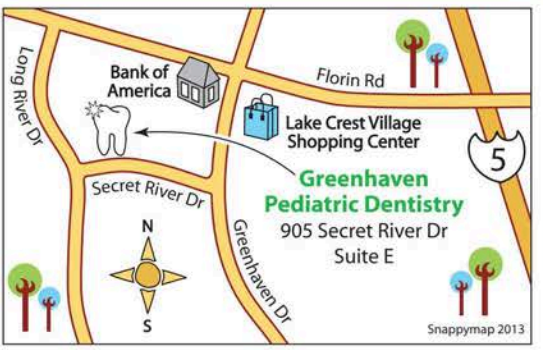
Radiographs ❑ None available ❑ X-rays taken

Please forward x-ray to: office@greenhavenpd.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



Greenhaven Pediatric Dentistry
905 Secret River Drive, Suite E • Sacramento, CA 95831
Tel: (916) 594-9444 • Fax: (916) 594-9337