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We're *Wild* About Smiles

Specializing in Infants, Children & Teens

Patrick Martin, DDS
Pediatric Dentist

Please provide a dental evaluation for:

Name: _____

- | | |
|---|---|
| <input type="checkbox"/> Infant Dental Care | <input type="checkbox"/> Dental Trauma |
| <input type="checkbox"/> Management of Behavior | <input type="checkbox"/> Eruption Problem |
| <input type="checkbox"/> Dental Decay | <input type="checkbox"/> Thumb/Finger Habit |
| <input type="checkbox"/> Bottle/Nursing Decay | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dental Infection | |

Date: ____ / ____ / ____

Remarks:

- X-rays taken on ____ / ____ / ____ Attached Will Send
- Please call to schedule Patient will call to schedule

Referred by Dr. _____ Phone: _____

A parent or legal guardian must accompany the child patient.