Aaron T. Schmick, DMD

Diplomate, ABPD

CHILDREN'S DENTISTRY OF MAINE

INTRODUCING

Patient Name: ______________________________ DOB: ____________________

Referred By: ____

Date: ____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

Patient Referred For:

☐ RESTORATIVE ☐ EXTRACTION ☐ SEDATION ☐ OR

X-Rays Taken: ☐ YES ☐ NO

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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Doctor's Signature

PRACTICE LOCATION

CHILDREN'S DENTISTRY OF MAINE

3 Eastview Parkway #2 Saco, ME 04072

Phone: 207-815-2050

Email: info@childrensdentistryofme.com