DISCOVERY PEDIATRIC DENTISTRY
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Dr. Melanie Perea-Corkish
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Dr. Bonnie Roy

Patient Name: _____ Phone: _____

Referred by: _____ Phone: _____

Patient Referred for:

_____

_____

_____

Please evaluate the following (circle affected areas):

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

Date of last Dental Exam: _____ Last Prophy: _____

Date of last X-rays taken: _____

X-rays: ☐ In the mail ☐ E-mailed ☐ Patient will bring them

☐ Please take necessary x-rays / No current radiographs available

Special Instructions or Remarks:

_____

_____

_____

To the Parent:

Please call our office at **(415)441-7766** to make an appointment. If you have dental insurance, please have your dental insurance information ready.
A co-payment may be required on the day of service.

Feel free to call us any time if you have any questions.

We look forward to meeting you!