



Pediatric Dentistry

Dr. Nadgie Ortiz  
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

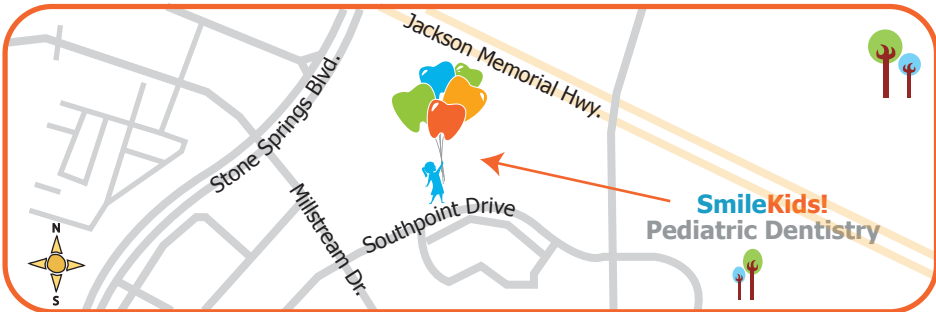
Radiographs    None available    X-rays taken

Please forward x-ray to: smilekidsva@gmail.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		
R				A	B	C	D	E	F	G	H	I	J					L
I																		E
G																		F
H				T	S	R	Q	P	O	N	M	L	K					T
T																		
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		



**SmileKids! Pediatric Dentistry**  
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