All Big Smiles

Start Little

Dr. Christine Armenian, DDS

Little Wonder
CHILDREN'S DENTISTRY

How can we help you? _____ Date _____

Little Wonder's Name _____ Date of Birth _____

Parent/Guardian Name _____ Phone _____

Referring Doctor's Name _____ Phone _____

Reason for referral:

- ☐ 1st Dental visit
- ☐ Comprehensive Care
- ☐ Toothache
- ☐ Trauma
- ☐ Decay
- ☐ Special Needs
- ☐ Sedation
- ☐ Other _____

Please specify which tooth or area:

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
				A	B	C	D	E	F	G	H	I	J				
				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	

Radiographs taken: _____ Date: _____

Any additional information: _____

Scan form & email (with available X-rays) to
email: info@littlewonderdentistry.com or
fax form: 818-296-0208

You can reach us at:
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