Pediatric Dental Care of Wilmington

Marcy Gabrilowitz, DMD
Pediatric Dentist

Referring Doctor: _____ Date: _____

Patient: _____ DOB: _____

Date of last cleaning: _____

Type and date of last xrays: _____

REASON(S) FOR REFERRAL:

- ☐ Request for restoration
- ☐ Request for extraction
- ☐ Request for space maintenance
- ☐ Recommended nitrous oxide sedation
- ☐ Recommended general anesthesia

Please verify which tooth/teeth you would like treated and include any special instructions that you have

Maxillary

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

Mandibular

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