referral

pediatric dentistry
of salisbury
Jean Ann Lewis DMD PC

Date _____

Dear Doctor: _____

Patient: _____

Please evaluate the following teeth noted below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

PERMANENT DENTITION

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

PRIMARY DENTITION

Best Regards _____

(410) 749-0133 • fax (410) 749-0284
677 S Salisbury Blvd
Salisbury, Maryland 21801