Dr. Samita Gumber
BDS, MDS, MS
Pediatric Dentist

GROWING SMILES
Children's Dentistry

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Patient's Name: _____

Age: _____ Gender: _____

Parent/Guardian: _____

Address: _____

Phone: _____

Reason for referral: _____

_____

18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28
55 54 53 52 51	61 62 63 64 65
85 84 83 82 81	71 72 73 74 75
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38

Radiographs Enclosed: ☐ Yes ☐ No

Any Special Considerations:

_____

Referred by Dr.: _____

Address: _____

Phone: _____

Date: _____