

Date _____

Patient Name _____

Parent Name _____

Phone _____ Patient Age _____

Date of Exam _____ X-rays (if different) _____

Any treatment provided? _____

Services requested/comments _____

Referring doctor/phone _____

little
PEARLS
DENTISTRY FOR CHILDREN

Michael K. Gazori, DDS
Specialist in Pediatric Dentistry

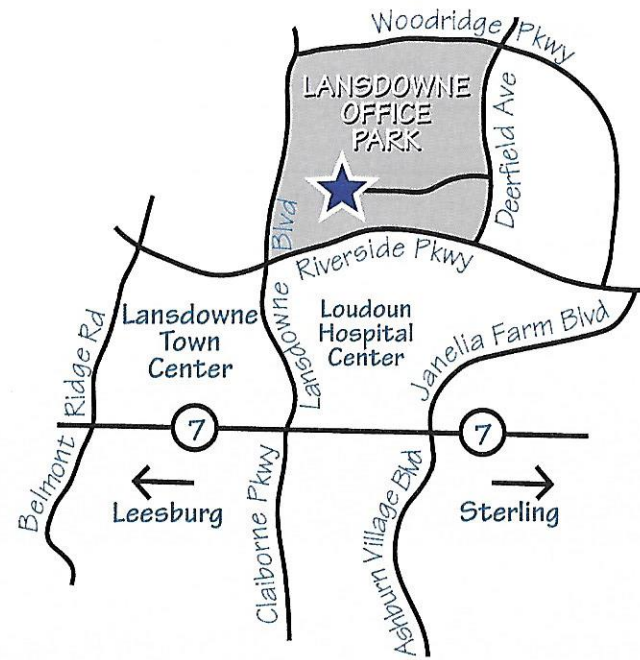
We believe...

each child is special and deserves to feel safe
each child should be treated with compassion and respect
dental health is fundamental to overall health and well-being
parents are our allies in the care of their children

For the parents

We are excited to meet you and your child. Your first appointment will be a consultation during which we will assess your child's needs and formulate a treatment plan together. Bring any x-rays that have been taken. Please visit our website to learn more about us and to download registration forms. If you do not have internet access, please call us and we will mail you the forms.

Appointment date and time _____
(please arrive 15 minutes early)



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