



Dr. Nyasha Scott, D.D.S.  
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INTRODUCING \_\_\_\_\_

REFERRED BY DR. \_\_\_\_\_

REFERRING DENTIST TEL. NO. \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Toothache      | <input type="checkbox"/> Sedation/Anesthesia      |
| <input type="checkbox"/> Decay          | <input type="checkbox"/> Radiographs              |
| <input type="checkbox"/> Special Needs  | <input type="checkbox"/> None Available           |
| <input type="checkbox"/> Trauma         | <input type="checkbox"/> X-rays sent with patient |
| <input type="checkbox"/> Comments _____ |   |

Please Email Radiographs to: [office@littlehouseofsmiles.com](mailto:office@littlehouseofsmiles.com)

PLEASE CIRCLE TEETH TO BE EVALUATED  
PERMANENT

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

PRIMARY

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

If you are unable to keep your appointment, we kindly ask for 48 hours notice.



Located inside the Sierra San Antonio Medical Plaza