12621 Hero Way W Suite A1 • Leander, TX 78641
T: 512-522-8282 • HeroWayPediatricDentistry@gmail.com

Please provide a dental evaluation for:

Patient's Name: ____ Age: _____

Parent's Name: ________________________ Phone Number: _____________

- ☐ Infant Dental Care
- ☐ Dental Decay
- ☐ Nitrous Oxide
- ☐ Sedation
- ☐ Dental Infection
- ☐ Dental Trauma
- ☐ Thumb/Finger Habit
- ☐ Other

Date of last visit with your office: ____________________________________

X-Rays taken: ________________________________ Date: ______________

☐ Attached ☐ Emailed

Referred by Dr. __________________________ Dr.'s Phone: _____________

Practice Name: ____

(A parent or legal guardian must accompany the patient)

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

Remarks: ____

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