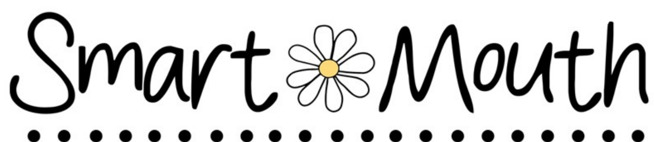

Pediatric Dentistry

Sheala Lansden, DDS
Board Certified Specialist In Pediatric Dentistry

254.399.9000
SmartMouthPediatricDentistry.com

Today's Date ____________________

Patient's Name ____

Parent's Name ____

Parent's Phone Number ____________________________________

Referred by Dr. __________________________ Phone ____________

Reason for referral:

- ☐ Decay/Treatment
- ☐ Sedation/Anesthesia
- ☐ Trauma
- ☐ Special Needs

Please evaluate the following teeth (please circle)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT				A	B	C	D	E	F	G	H	I	J				LEFT
				T	S	R	Q	P	O	N	M	L	K				
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Comments and special instructions ____________________________

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____

____

____

Prophylaxis completed on ______________________________________

Date of last bitewing x-ray ____________________________________

Date of last panoramic x-ray ___________________________________

- ☐ Sent with patient
- ☐ Will mail / email

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