DENTAL LAND pediatrics

Dinah Abioro, DDS
Board Certified, American Board of Pediatric Dentistry

Patient Name_____ Age_____

Please Evaluate For:

- ☐ 1st Dental Visit
- ☐ Space Maintenance
- ☐ Trauma/Emergency
- ☐ Dental Caries/Cavities
- ☐ Sedation/General Anesthesia
- ☐ Dental Fear/Anxiety
- ☐ Special Needs
- ☐ Extractions
- ☐ Other_____

Radiographs:

- ☐ Parents Will Bring
- ☐ Will Be Mailed
- ☐ None Available
- ☐ Will email to administrator@dentallandpediatrics.com

Please Circle Teeth To Be Evaluated/Treated

Primary Teeth

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

Permanent Teeth

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

Comments_____

Referring Doctor_____ Phone_____

Date_____

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