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Please provide a dental evaluation for:

NAME: _____

- ❑ **Infant Dental Care**
- ❑ **Management of Behavior**
- ❑ **Dental Decay**
- ❑ **Dental Infection**
- ❑ **Dental Trauma**
- ❑ **Eruption Problem**
- ❑ **Thumb/Finger Habit**
- ❑ **Other**

Remarks: **Date:** ____/____/____

_____

_____

_____

_____

_____

Date of last visit with your office: ____/____/____

X-rays taken: _____ **Date:** ____/____/____ ❑ **Attached** ❑ **Will Send**

Referred by Dr. _____**Phone:** _____

(A parent or legal guardian must accompany the child patient)

Member, American Academy of Pediatric Dentistry

Raleigh Pediatric Dentistry

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