

RENEE COMMARATO, D.D.S., M.S., INC.  
 Pediatric Dentistry  
 8845 East Market Street • Warren, Ohio 44484  
 (330) 394-1516 • fax (330) 394-1517

Date \_\_\_\_\_

This will introduce \_\_\_\_\_  
 Name Phone

From Dr. \_\_\_\_\_

PLEASE EVALUATE THE FOLLOWING TEETH:

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

Please Evaluate Patient For:

- I.V. Sedation       Extractions: \_\_\_\_\_  
 Carious Lesion(s): \_\_\_\_\_       Other: \_\_\_\_\_

Behavior in Office: Cautious    Gaggy    Grabby    Cried    Uncooperative

Previous Treatment Completed: \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

